History and Physical

Ht: _________ Wt: _________ BP: _________ R-BP_________
Pulse: __________ Resp Rate: __________ Temp: __________
Vision: R_________ L_________B__________
Hearing: ______________________________

Name: ____
Last First MI

Address: ____

DOB: _______________ Occupation: ______________________

Phone: ____
Home Cell Work

How did you hear about us? ____________________________

Please check if you have or have had any of the following:

☐ Asthma ☐ Hypertension ☐ Depression ☐ Psychiatric Disorder
☐ Hepatitis B ☐ Seizures ☐ Blood Clots ☐ Bleeding Disorder
☐ Hepatitis C ☐ Heartburn ☐ Diabetes ☐ Heart Disease
☐ Ulcers ☐ Hayfever ☐ Migraines ☐ Elevated Cholesterol
☐ Urinary Difficulties ☐ Thyroid Disease ☐ Cancer
☐ Other Please Specify: ___________________________________

Comments: ____

Immunizations:

Last Tetanus: _____________
Last TB: _______________ Positive ☐ Y ☐ N
Hepatitis A Series: _________________
Hepatitis B Series: _________________
Flu: _________________
Meningococcal: _________________

Date of last Preventative:

Colonoscopy: Year________ Normal? ☐ Y ☐ N
Pap: Year________ Normal? ☐ Y ☐ N
Mammogram: Year________ Normal? ☐ Y ☐ N
Dexascan: Year________ Normal? ☐ Y ☐ N

Medications:
List all medications, vitamins and supplements/Dose.
______________________________________/__________
______________________________________/__________
______________________________________/__________
______________________________________/__________
______________________________________/__________

Please list past surgeries and hospitalization with dates:
____
____

Allergies/ Reaction:
________________________/____________________________
________________________/____________________________
________________________/____________________________

Preferred Pharmacy? ______________________________

Family History: Please check medical problems **immediate family members** have or have had in the past.

	Father	Mother	Children			Siblings			Fathers Parents		Mothers Parents	
			1	2	3	1	2	3	M	D	M	D
			M/F	M/F	M/F	M/F	M/F	M/F				
Alive												
Deceased (Cause)												
Alcoholism												
Asthma												
Bleeding Disorder												
Blood Clots												
Brain Aneurysm												
Cancer (list type)												
Colon Polyps												
Depression												
Diabetes												
Glaucoma												
Heart Disease												
High Blood Pressure												
High Cholesterol												
Kidney Disease												
Mental Illness												
Migraines												
Osteoporosis												
Thyroid Disease												

Tobacco ☐ Y ☐ N __________________ (packs/can/day)
Former Tobacco User_________________ (date quit)
Alcohol ☐ Y ☐ N__________________ (drinks/week)
Recreational Drugs ☐ Y ☐ N__________________ (type)
Exercise ☐ Y ☐ N______________________ (time/week)
Caffeine ☐ Y ☐ N ______________________ (cups/day)
Sleep: Difficulty Falling Asleep ☐ Y ☐ N
Continuity Disturbances ☐ Y ☐ N
Early Morning Awakening ☐ Y ☐ N
Daytime Drowsiness ☐ Y ☐ N

Females Only:
Last Menstrual Period: _______________
Current method of birth control: ______________
Has your partner had a vasectomy? ☐ Y ☐ N
Total number of pregnancies: _____ Live Births: _____
Miscarriages/Abortions: ____ /_____
Menopause: ☐ Y ☐ N
Hysterectomy: ☐ Y ☐ N

Signature: _______________________________________ Date: ____________________