HISTORY & PHYSICAL

DATE

NAME

M F MARITAL STATUS S M W D SEP

DATE OF BIRTH

Formedic

PAGE #

CHART #

ADDRESS

PHONE (H) (O)

OCCUPATION/ EMPLOYER

INSURANCE

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

1) Epilepsy	6) Thyroid disease	11) Osteoporosis	16) Lipid disorder
2) Migraine	7) Hay fever	12) Arthritis	17) Alcoholism
3) Mental illness	8) Asthma	13) Heart disease	18) Hepatitis
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer
5) Diabetes	10) Bleeds easily	15) Hypertension	20)

HOSPITAL ADMISSIONS

not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING

ALLERGIES

SUPPLEMENTS

VACCINE

	YEAR OF LAST
Tetanus / Td	
Influenza (flu)	
Pneumonia	
Hepatitis	
Tuberculosis	

TEST / EXAM

	YEAR OF LAST
Rectal / Stool	
Cholesterol	
Eye	
Dental	

MEDICAL HISTORY

MARK (C) FOR CURRENT PROBLEMS. CHECK (✓) AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES.

MAIN PROBLEM

- ☐ Hearing problems ☐ Ringing in ear
- ☐ Dizzy spells ☐ Fainting spells
- ☐ Vision problems ☐ Eye pain
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath: ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain ☐ Cold numb feet
- ☐ Varicose veins / Phlebitis
- ☐ Appetite ☐ Difficulty swallowing ☐ loss ☐ gain
- ☐ Heartburn ☐ Peptic ulcer
- ☐ Nausea / Vomiting ☐ Gallbladder dis
- ☐ Abdominal pain- *chronic*
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or tarry stools
- ☐ Hemorrhoids ☐ Hernia
- Urination - Overactive bladder
  - ☐ Overnight > than twice
  - ☐ More than 8 times / 24 hrs.
  - ☐ Urgency to urinate ☐ with leakage
- ☐ Decrease in force/flow ☐ Painful
- ☐ Stress incontinence-urine leakage with exercise / movement
- ☐ Blood in urine ☐ Kidney stones
- ☐ Urine infections ☐ Prostate prob
- ☐ Bed wetting
- ☐ Weight-loss ☐ gain
- ☐ Anemia ☐ Bruise easily
- ☐ Cancer ☐ Fatigue / loss of energy
- ☐ Diabetes ☐ Thyroid disease
- ☐ Arthritis / Rheumatism ☐ Back pain
- ☐ Bone fracture / joint injury
- ☐ Osteoporosis ☐ Gout
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Seizures ☐ Stroke
- ☐ Tremor/hands ☐ Numbness
- ☐ Headaches
- ☐ Concentration prob ☐ Memory loss
- ☐ Depression ☐ Moodiness
- ☐ Decreased life enjoyment
- ☐ Decreased work performance
- ☐ Thoughts of death ☐ suicide
- ☐ Sleep problems - how long ___ how often ___ ☐ waking refreshed ☐ sleeping too much
- ☐ Anxiety ☐ Phobias
- ☐ Mental illness
- ☐ Sexual problems / enjoyment
- ☐ Rheumatic fever ☐ Measles
- ☐ Chicken pox ☐ Polio ☐ Mumps
- ☐ Tuberculosis ☐ German measles
- ☐ Herpes ☐ Aids / HIV ☐ STD
- ☐ Alcohol ___ oz. per week
- ☐ Coffee / Tea ___ cups per day
- ☐ Smoking- cig/day ___ # years year quit ___
- ☐ Hair loss: ☐ Progressive ☐ Recent
- ☐ Exercise
- ☐ Street Drugs

FEMALES - *Please complete*

Menstrual flow:

☐ Reg. ☐ Irreg. ☐ Pain / Cramps

Days of flow ___ Length of cycle ___

Date -1st day of last period

☐ Pain / Bleeding during or after sex

Number of:

Pregnancies ___ Abortions ___

Miscarriages ___ Live births ___

Birth control method

☐ Flushing / Menopause

Date of last PAP test

☐ Normal ☐ Abnormal

Date of last mammogram

☐ Normal ☐ Abnormal

SYNOPSIS