

HISTORY & PHYSICAL

Name _____ SS# _____ Date of Birth _____

ADVANCED DIRECTIVE HAS BEEN FILLED OUT FOR RECORD: Circle Answer YES NO

Please feel free to request one from our office if you are interested.

FOOD & DRUG ALLERGIES/Describe reaction

FAMILY HISTORY

CURRENT MEDS

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

IMMUNIZATIONS:

ADULT

CHILDREN

Td: Last Dose _____	Please Provide Your
Flu: Last Dose _____	Current Immunization
Pneu: Last Dose _____	Record To Comply With
Hep B: Last Dose _____	State Regulations

MEDICAL HISTORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Lactose intolerance _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Shortness of breath _____ | <input type="checkbox"/> Gallbladder disease _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Heart palpitations _____ | <input type="checkbox"/> Prostate disease _____ | <input type="checkbox"/> Scarlet fever _____ |
| <input type="checkbox"/> Heart murmur _____ | <input type="checkbox"/> Bowel irregularity _____ | <input type="checkbox"/> Chronic rashes _____ |
| <input type="checkbox"/> Chest pain _____ | <input type="checkbox"/> Incontinence _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Dizziness / Fainting _____ | <input type="checkbox"/> Sexual / menstrual dysfunction _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Peripheral vascular disease _____ | <input type="checkbox"/> Venereal disease _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Frequent infections _____ | <input type="checkbox"/> Rubella _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Diphtheria _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Ulcer _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> GI disorder _____ | <input type="checkbox"/> Nervousness _____ | |

WOMEN ONLY:

Pregnant? Yes No

Yes No

Planning pregnancy? Yes No

Yes No

MEN ONLY: *It's common for men to occasionally experience erection difficulties. Is this something that happens to you?* Yes No

How often does this occur? Frequently Sometimes Rarely

HABITS

- | | | |
|---|--|---|
| <input type="checkbox"/> Smoke: Packs Daily _____
How long? _____
Interested in stopping? _____ | <input type="checkbox"/> Coffee: Cups Daily _____
Other caffeine _____ | <input type="checkbox"/> Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____ |
| <input type="checkbox"/> Exercise Routine: _____ | <input type="checkbox"/> Alcohol: Type _____
Amount _____ | |
| | <input type="checkbox"/> Illicit Drug Use: Type: _____
Frequency: _____ | |
| | <input type="checkbox"/> Diet: Salt intake _____
Fat intake _____ | |