HISTORY & PHYSICAL

DATE

Formedic

PAGE #

CHART #

NAME

M F MARITAL STATUS S M W D SEP

DATE OF BIRTH

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) Hay fever	11) Arthritis	16) Cancer
2) Migraine	7) Asthma	12) Heart disease	17) Restless leg syndrome
3) Glaucoma	8) Anemia	13) Stroke	18) Depression
4) Diabetes	9) Bleeding disorder	14) Hypertension	19) Alcoholism
5) Thyroid disease	10) Osteoporosis	15) Lipid disorder	20) Mental illness

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	VACCINE	YEAR OF LAST
Tetanus / Td		MMR Measles Mumps Rubella	
Influenza (flu)			
Pneumonia		Meningitis	
Hepatitis A		Chicken pox	
Hepatitis B		HPV	
Whooping C		Shingles	

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
  Date of last eye exam
- ☐ Nose bleeds ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
  Date of last TB test
- ☐ Shortness of breath:
  ☐ on exertion ☐ lying flat
  ☐ in the past week
  ☐ affects work lifestyle
- ☐ Chest pain ☐ High blood pressure
  Date of last cholesterol test
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain ☐ Cold numb feet
- ☐ Varicose veins / Phlebitis
- ☐ Appetite ☐ Difficulty swallowing
  ☐ loss ☐ gain

- ☐ Heartburn ☐ Peptic ulcer
- ☐ Aspirin - arthritis - pain pills
- ☐ Nausea / vomiting ☐ Gallbladder dis
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or tarry stools
- ☐ Test for blood in stool
- ☐ 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
- ☐ Excessive sweating
- ☐ Seizures ☐ Stroke
- ☐ Tremor/hands ☐ Numbness
- ☐ Headaches ☐ Memory loss
- ☐ Depression ☐ Confusion
- ☐ Decreased work performance
- ☐ Sleep problems
  for how long ____ how often ____
  sleeping - ☐ too little ☐ too much
  waking refreshed ☐ yes ☐ no
  ☐ Legs keep you up at night
- ☐ Concentration problems
- ☐ Difficulty with unfamiliar tasks
- ☐ Thoughts of death ☐ suicide
- ☐ Anxiety ☐ Mood swings ☐ Phobias
- ☐ Mental illness
- ☐ Sexual problems / enjoyment
- ☐ Rheumatic fever ☐ Measles
  ☐ Chicken pox ☐ Polio ☐ Mumps

- ☐ Tuberculosis ☐ German measles
- ☐ Herpes ☐ Aids / HIV
- ☐ Sexually transmitted diseases - # of encounters
- ☐ Alcohol ____ oz. per week
- ☐ Coffee / Tea ____ cups per day
- ☐ Smoking- cig/day ____ # years
  year quit
- ☐ Exercise
- ☐ Street drugs
- ☐ Travel abroad

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