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HISTORY & PHYSICAL

NAME: _____ **MALE** **FEMALE**
OTHER NAMES USED: _____
ADDRESS: _____
PHONE # _____ **DOB** _____ **AGE** _____
ALTERNATE # _____ **SS#** _____
PRIMARY PHYSICIAN _____ **PHONE** _____
REFERRING PHYSICIAN _____ **PHONE** _____
PHARMACY _____ **LOCATION** _____ **PHONE** _____

What is the nature of your problem? _____

List of current medical problems and doctors/specialists

Medical Problem	Doctor	Medical Problem	Doctor
1. _____	_____	5. _____	_____
2. _____	_____	6. _____	_____
3. _____	_____	7. _____	_____
4. _____	_____	8. _____	_____

Please list all of your prior surgeries

Operation	Date	Surgeon/Hospital	Complications
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Have you been hospitalized for any reason other than the above listed surgeries?

1. _____
2. _____
3. _____

What medications do you take? (Include prescription, over the counter, vitamins, natural supplements)

- 1. _____ 6. _____
- 2. _____ 7. _____
- 3. _____ 8. _____
- 4. _____ 9. _____
- 5. _____ 10. _____

Have you used Aspirin/ibuprofen/blood thinner in the past week? Yes No

Do you have drug allergies?

Name	Reaction	Name	Reaction
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Is there any family history of heart disease, hypertension, diabetes, bleeding disorders or problems with anesthesia?

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Any family history of Breast cancer?

Ovarian cancer?

Who: _____

Uterine cancer?

Who: _____

Colon cancer?

Who: _____

Prostate cancer?

Who: _____

Pancreatic cancer?

Who: _____

Melanoma?

Who: _____

Other cancers?

Who: _____

Who: _____

Do you have Jewish Ancestry? Yes No

Occupation _____ Are you married? _____

Number of Children? _____ Number of Pregnancies _____ Did you breast feed? _____

Date of 1st menstrual period _____ Age of last menstrual period _____

Did you ever use oral contraceptives? _____ For how long? _____

Have you ever taken hormones? _____ For how long? _____

Do you smoke? _____ How much? _____ Did you quit? How long ago? _____

Do you drink? _____ How much? _____

Do you use IV drugs? _____ Did you ever? _____ When did you stop? _____

Do you drink caffeinated beverages? _____ How Much? _____

Last PAP _____ Doctor _____

Last Colonoscopy _____ Doctor _____

Last Mammogram _____ Doctor _____

Is there anything else you would like us to know? _____

REVIEW OF SYSTEMS

Please check any of the following problems which apply to you. If none apply, please check "none"

GENERAL

- Weight Loss
- Weight gain
- Fevers
- Night Sweats
- Decreased energy
- Decreased strength
- None

HEENT

- Change of vision
- Blurry vision
- Floaters
- Double Vision
- Blind spot
- Ear pain
- Ringing ears
- Nose bleeds
- Sinus Problems
- Bleeding gums
- Dental difficulties
- Hoarseness
- Neck stiffness
- Neck tenderness
- Neck masses
- None

CARDIOVASCULAR

- Chest pains
- Palpitations
- High Blood Pressure
- Leg swelling
- Lightheadedness
- Heart murmurs
- Varicose veins
- Blue toes
- Calf pain when walking
- Shortness of breath while sleeping

RESPIRATORY

- Pain in chest
- Wheezing
- Cough
- Sputum
- Bloody sputum
- Emphysema
- Tuberculosis
- Shortness of breath
- Asthma
- Pneumonia
- Infections

GASTROINTESTINAL

- Change in appetite
- Nausea
- Vomiting
- Heartburn
- Reflux
- Ulcers
- Food intolerance
- Hernia
- Abdominal Pain
- Hemorrhoids
- Bloody stool
- Jaundice
- Diarrhea
- Constipation
- Abnormal stools
- Excessive gas
- Change in bowel habits

GENITOURINARY

- Incontinence
- Urgency
- Frequency
- Blood in urine
- Change in urine color
- Bladder infection
- Change in stream
- Kidney Stones
- Pain on urination
- Sexual dysfunction
- Change in libido
- Heavy periods
- Painful periods
- Painful intercourse
- Vaginal discharge
- Genital sores
- Sexually transmitted disease
- Post-menopausal bleeding

MUSCULOSKELETAL

- Bone pain
- Joint pain
- Arthritis
- Motion limitation
- Muscle weakness
- Muscle cramps
- None

SKIN

- Rash
- Itching
- Infections
- Nail changes
- Change in mole

BREAST

- Lumps
- Pain
- Change in shape
- Nipple discharge
- Change in skin
- Tenderness
- None

