HISTORY AND PHYSICAL (PLEASE PRINT)

PATIENT NAME:_____

REASON FOR VISIT:_____

HAVE YOU HAD A FLU SHOT THIS YEAR? YES__ NO__HAVE YOU HAD A PNEUMONIA SHOT THIS YEAR? YES__NO__

********** **IF WORKERS COMP, PLEASE CHECK THIS BOX:** ☐ **********

PERSONAL MEDICAL HISTORY- CHECK YES OR NO, THEN CIRCLE CONDITION THAT APPLY'S

__**yes** __ **no** ***GENERAL***: weight gain or loss, change in energy level, appetite change, other: _____
__**yes** __ **no** ***NEUROLOGICAL***: weakness, muscle spasms, numb feet, dizziness, chronic pain, epilepsy, seizures, Other_____
__**yes** __ **no** ***PSYCHIATRIC***: increased nervousness, mood changes, depression, tension, other_____
__**yes** __ **no** ***EYES***: glasses, vision changes, dry eyes, double vision, other_____
__**yes** __ **no** ***EARS/NOSE/ MOUTH/ THROAT***: ringing of ears, hearing loss, bleeding gums, nose bleeds, hoarseness, difficulty swallowing, sinus problems, sores in mouth, other _____
__**yes** __ **no** ***RESPIRATORY*****:** infections, difficulty breathing, cough, coughing blood, asthma, wheezing, Exposure to tuberculosis, emphysema, pneumonia, other_____
__**yes** __ **no** ***CARDIAC***: chest pain, heart flip-flops, fast heartbeat, breathing difficulty when sleeping, shortness of Breath with activity, sleeping with multiple pillows to breath, heart attack, stroke, high blood pressure, Rheumatic fever, other_____
__**yes** __ **no** ***GASTROINTESTINAL***: ulcers, GERD, acid reflux, abdominal pain, nausea, vomiting, diarrhea, bloody Or black stool, enlarged liver, hepatitis, alcoholism, exposure to chemicals, other_____
__**yes** __ **no** ***URINARY SYSTEM***: flank pain, kidney disease, bladder problems, burning with urination,other_____
__**yes** __ **no** ***MUSCULOSKELETAL***: muscle pain, joint stiffness or swelling, limited motion, back problems, Balance issues, arthritis, gout, osteoporosis, other_____
__**yes** __ **no** ***ENDOCRINE***: thyroid issues, diabetes, excessive thirst or hunger, excessive urination, heat or cold Intolerance, prostate issues (if male), other_____
__**yes** __ **no** ***VASCULAR***: leg cramps, varicose veins, poor circulation, cold sensitivity, pulsations in legs/feet, History of frostbite, other_____
__**yes** __ **no** ***BLOOD***: anemia, easy bruising, bleeding problems, enlarged lymph nodes, transfusions, drug abuse, Exposure to HIV/AIDS, HEPATITIS—what type_____
__**yes** __ **no** ***ALLERGIES***: hay fever, throat problems, latex sensitivity, metal sensitivity, history of anaphylaxis, Other_____
__ **yes** __ **no** ***SKIN / BODY***: rashes, non-healing lesions, sores, psoriasis, recent bug bites, tumor, abnormal growth, Cancer, other_____
__**yes** __ **no** ***OTHER CONDITIONS***: _____

ALLERGIES PLEASE CHECK "NONE" IF NO KNOWN ALLERGIES

MEDICATION ALLERGIES- List Below-- **NONE_____**
1._____----Reaction_____
2._____----Reaction_____
3._____----Reaction_____
4._____----Reaction_____

***FOR OFFICE USE ONLY**Reviewed with Patient Date:_____ Signature:_____

PERSONAL INFORMATION

Do you Smoke? Yes___ No___ Packs per day? _____ How Long?_____
Did you smoke previously? Yes___ No ___ If Yes, when did you quit?_____
Do you chew Tobacco? Yes___ No ___ If Yes, how long? _____
Do you consume products with caffeine? Yes___ No ___ If Yes, How many per day?_____
Alcohol? Yes___ No ___ If Yes, How many drinks per week?_____
Height_____ Weight_____ Shoe Size _____

SURGICAL HISTORY

PREVIOUS SURGERIES	LEFT OR RIGHT (IF APPLICABLE)	YEAR	PHYSICIAN
1.			
2.			
3.			
4.			
5.			

PRESCRIPTION MEDICATIONS (CURRENT AND DOSAGE)

NAME OF MEDICATION	DOSAGE	HOW TAKEN(one/two times a day?)
1.		
2.		
3.		
4.		
5.		

Over the counter Medications/ Vitamin: _____

PHARMACY INFORMATION

_____ _____ _____
PHARMACY NAME **LOCATION** **PHONE NUMBER**

FAMILY HISTORY (PLEASE COMPLETE AS BEST YOU CAN)

___ ADOPTED

Please state if your relatives listed below have or have had any of the following: Cancer, Heart Trouble, Kidney Disease, Stroke, Arthritis, Diabetes, High Blood Pressure, Tuberculosis, Emphysema.

Health Problem	Age (if living)	Age (if deceased)	Cause of Death
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Children			
Children			

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records by fax, mail or phone either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my conditions with x-rays, examination, photographs or injections as necessary.

_____ _____ _____

PATIENT NAME (PLEASE PRINT) PATIENT SIGNATURE DATE

REVISED 9/2/14