HISTORY & PHYSICAL

Name______________________________________

Date________________ Date of Birth_____________

CURRENT MEDICATIONS

HOSPITALIZATION AND SURGERY

DATE	REASON

DRUG ALLERGIES

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

___ ANEMIA ___BRUISE EASILY	___NUMBNESS/TINGLING SENSATIONS
___ BACK PAIN - RECCURENT	___ OSTEOPOROSIS
___ BONE FRACTURE/JOINT INJURY	___ PROSTATE DISEASE
___ CANCER	___PSORIASIS ___ECZEMA
___ CONVULSIONS/SEIZURES	___SEXUAL/MENSTRUAL DYSFUNCTION
___DIABETES	___STOOLS - BLODDY OR TARRY
___ DIVERTICULOSIS ___ CROHN'S/COLITIS	___STROKE
___ FOOT PAIN ___ COLD NUMB FEET	___ SWALLOWING DIFFICULTY
___GALL BLADDER TROUBLE	___THYROID DISEASE
___ GOUT	___TREMOR/HANDS SHAKING
___ HEART MURMUR	___ULCERS - PEPTIC
___ HERNIA	___URETHRAL DISCHARGE
___ HIGH BLOOD PRESSURE	___VENEREAL DISEASE
___ JAUNDICE/HEPATITIS	___ WEIGHT LOSS - RECENT
___ KIDNEY STONES	___ CHICKEN POX ___ POLIO ___MUMPS
___LACTOSE INTOLERANCE	___ MEASLES ___RUBELLA
___ MEMORY LOSS	___RHEUMATIC FEVER ___SCARLET FEVER
___MENTAL ILLNESS	___TUBERCULOSIS ___ HERPES
___MUSCLE WEAKNESS	___OTHER ___________________________
___NERVOUSNESS ___DEPRESSION	___OTHER ___________________________

FEMALES (PLEASE COMPLETE)

PREGNANT? ___ YES ___ NO ___NOT SURE

PLANNING PREGNANCY? ___YES ___NO

MENSTRUAL FLOW: ___ REGULAR ___IRREGULAR

BIRTH CONTROL METHOD: _______________________

B.C PILL (NAME):______________________________

MENOPAUSE: ___YES ___NO

DATE OF LAST PERIOD: __________________________

HABITS										
___ ALCOHOL: TYPE_________________				___ SMOKE: PACKS DAILY______________					___ CAFFEINE	
AMOUNT_____________					HOW LONG _______________				___________________	