HISTORY & PHYSICAL

DATE

NAME | M F | MARITAL STATUS S M W D SEP | DATE OF BIRTH

Formedic

PAGE #

CHART #

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

Epilepsy	Hay fever	Arthritis	Hepatitis
Migraine	Asthma	Heart disease	Cancer
Glaucoma	Anemia	Stroke	Depression
Diabetes	Bleeding disorder	Hypertension	Alcoholism
Thyroid disease	Osteoporosis	Lipid disorder	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)

Tetanus / Td
Influenza (flu)
Pneumonia
Hepatitis
Tuberculosis

TEST / EXAM (YEAR OF LAST)

Rectal / Stool
Cholesterol
Eye
Dental

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
- ☐ Nose bleeds - *recurrent*
- ☐ Sinus trouble
- ☐ Sore throats - *frequent*
- ☐ Hoarseness - *prolonged*
- ☐ Hayfever / Allergies
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing
- ☐ Shortness of breath: ☐ on exertion ☐ lying flat
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Swollen ankles
- ☐ Irregular pulse ☐ Palpitations
- ☐ Leg pain ☐ Cold numb feet
- ☐ Varicose veins / Phlebitis
- ☐ Appetite ☐ loss ☐ gain ☐ Difficulty swallowing

- ☐ Heartburn ☐ Peptic ulcer
- ☐ Nausea / Vomiting ☐ Gallbladder dis
- ☐ Abdominal pain- *chronic*
- ☐ Jaundice / Hepatitis
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Crohn's / Colitis
- ☐ Bloody or tarry stools
- ☐ 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
- ☐ Seizures ☐ Stroke
- ☐ Tremor/hands ☐ Numbness
- ☐ Headaches ☐ Memory loss
- ☐ Depression
- ☐ Decreased life enjoyment
- ☐ Decreased work performance
- ☐ Sleep problems for how long ____ how often ____ sleeping - ☐ too little ☐ too much ☐ waking refreshed
- ☐ Concentration problems
- ☐ Thoughts of - death ☐ suicide
- ☐ Anxiety ☐ Mood swings ☐ Phobias
- ☐ Vague aches and pains
- ☐ Mental illness
- ☐ Sexual problems / enjoyment
- ☐ Rheumatic fever ☐ Measles ☐ Chicken pox ☐ Polio ☐ Mumps

- ☐ Tuberculosis ☐ German measles ☐ Herpes ☐ Aids / HIV ☐ STD
- ☐ Alcohol ____ oz. per week
- ☐ Coffee / Tea ____ cups per day
- ☐ Smoking- cig/day ____ # years ____ year quit
- ☐ Hair loss: ☐ Progressive ☐ Recent
- ☐ Exercise ____
- ☐ Street Drugs ____

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