

History & Physical Form

Complete both sides of this form. **If a section does not apply to you**, please address it with an *N/A*, so we don't assume you've overlooked it.

Patient Name: _____ Date: ____/____/____ Chart #: _____

Please Print (Office Use Only) **Last** **First** **MI**

List your **Main Complaint(s)**: _____

Describe your condition (*i.e. onset, cause, etc.*)
: _____

List the date & type of diagnostic procedures (*i.e. MRI's, C/T Scans, X-ray's etc.*) you've had, which pertain to the condition you're being evaluated for today:

Medical History & Review of Systems

Do you or have you had any of the following?

Transmissible Disease(s): None Hepatitis A-B-C HIV TB

Other _____

Neurological: Headaches Stroke Epilepsy Aneurysm Other _____

Cardiovascular: Chest Pain High Blood Press. Heart Disease Other _____

Respiratory: Lung Disease Asthma Shortness of Breath Other _____

Are you a smoker? No Yes # of years _____ # of packs per day _____

Gastrointestinal/Adb. & Pelvis: Ulcer Hernia Hysterectomy Other _____

Musculoskeletal: MSD Arthritis Back or Neck Pain Other _____

Metabolic: Liver Disease Thyroid Disorder Bleeding Disorder Cancer Diabetes Meds. _____ Insulin _____
 Other _____ *check one*

Genito-Urinary: Kidney Disease Painful Urination Freq. Urination Poss. Pregnancy Sexual Dysfunction

Eye Problems: Blindness Cataracts Glaucoma Vision Difficulty

E.N.T.: Hearing Loss Deaf Swallowing Problems Nose Bleeds

Psychological: Anxiety Depression Fatigue Nervousness Other _____

Previous Hospitalizations/Surgeries (List Type and Year)

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

See Attached

Medications you are currently taking:

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |

See Attached

List Allergies:

1. _____ 2. _____
 3. _____ 4. _____
 5. _____ 6. _____

See Attached

List Your Employer: _____ Hrs. worked perwk. _____ Duties: _____

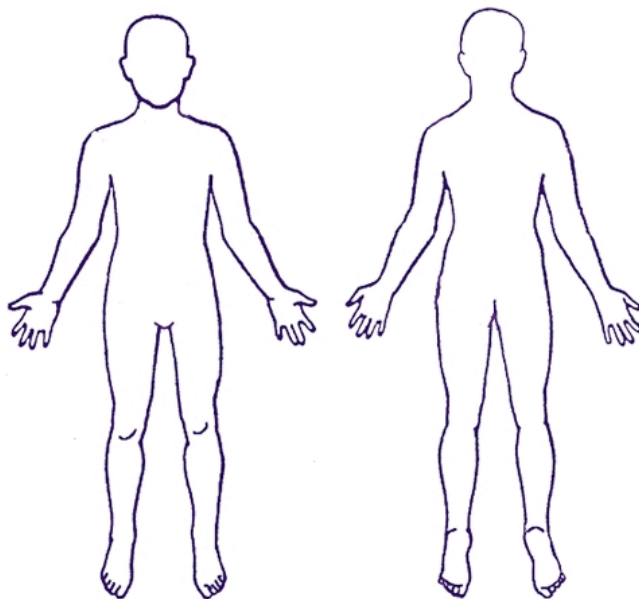
Patient Social History

- | | | | |
|----------------------|--|--------------------------------|---|
| 1. Use of Alcohol | _____ Never _____ Rarely
_____ Moderate _____ Daily | 2. Use of Drugs | Type/Freq. _____
<input type="checkbox"/> Never |
| 3. Sleep Habits | _____ | 4. Exercise Habits | _____ |
| 5. Diet | _____ | 6. Sexually Related Complaints | _____ |
| 7. Leisure (Hobbies) | _____ | 8. Education | High School/ Number of years. _____
G.E.D. _____ College # of yrs. _____ |
| 9. Stress Level | _____ | | |

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Sibling(s)			
Spouse			
Children			

Please **SHADE** the areas where your experiencing the most pain on the diagram listed below:



Pain Rating

On a scale of 0 (no pain) to 10 (excruciating pain), how would you rate your pain:

At rest _____, with normal activity _____, at work _____.