*** PLEASE PRINT ***

SAVE FORM | PRINT FORM | CLEAR FORM

TODAY'S DATE: _____
(This form is good for 1 year from above date).

TEMP: _____ BP: _____
HT: _____ P: _____
WT: _____ R: _____

NEW PATIENT HISTORY AND PHYSICAL FORM

(For new patients and to be updated annually)

PATIENT'S NAME: **AGE:**

CHIEF COMPLAINT: (Why you are here today)

HISTORY OF PRESENT ILLNESS:

- **Location** of pain/problem?
- **How long** have you had this problem?
- How did the problem **start**?
- How **often** do you have the pain?
- What makes it **worse**?
- What makes it **better**?
- What **associated problems** have you been having?
- What is the **severity** of your pain? Mark an **X** on the appropriate circle below:

(No Pain) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Extreme Pain)

- What does the pain **feel** like? (throbbing, shooting, sharp, etc)

GENERAL MEDICAL INFORMATION:

My general health is: (Please check one) ☐ Excellent ☐ Very Good ☐ Good ☐ Fair

Who is your family doctor: _____ **Date of last visit:** _____

Are you pregnant or attempting to get pregnant: ☐ YES ☐ NO

List any medications you are currently taking including strength and how often taken:

NAME	*DOSAGE*	*HOW OFTEN*	*NAME*	*DOSAGE*	*HOW OFTEN*

Are you currently taking (or have you taken in the past) diet pills or herbal supplements? ☐ YES ☐ NO

If yes, write name of the pill/supplement and date last taken: _____

ALLERGIES:

List medications and/or foods that you are ALLERGIC to or have had a bad reaction to:

_____

What kind of reaction did you have? _____

PAST MEDICAL HISTORY:

Check any problem you have ever been treated for and indicate the year of treatment:

- ☐ Arthritis
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Brittle Bones
- ☐ Broken Bones
- ☐ Ruptured Disc
- ☐ Sciatica
- ☐ Spinal Curvature
- ☐ Diabetes
- ☐ Stomach Ulcers
- ☐ Hypertension
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ Peripheral Vascular Disease
- ☐ Stroke
- ☐ Blood Clots
- ☐ Vericose Veins
- ☐ Kidney Disease
- ☐ Bladder Infection
- ☐ Sickel Cell Anemia
- ☐ Blood Transfusion
- ☐ Hepatitis
- ☐ Cirrhosis
- ☐ Gall Stones
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Polio
- ☐ Venereal Disease
- ☐ Asthma
- ☐ Emphysema
- ☐ Cancer
- ☐ Hereditary Defects
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Depression
- ☐ Drug Dependency
- ☐ Head Injury
- ☐ Convulsions
- ☐ Fainting Spells
- ☐ Insomnia
- ☐ Gout

SURGICAL/HOSPITALIZATION HISTORY:

PRIOR SURGERIES:

Type of Surgery	Date of Surgery
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PRIOR NON-SURGICAL HOSPITALIZATIONS, MAJOR ILLNESSES OR INJURIES:

Reason for Admit	Date of Admit
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Occupation: _____ **Marital Status:** ☐ S ☐ M ☐ W ☐ Dv ☐ Sp

Are you working now? _____ **If no, when did you work last?** _____

Place of Birth: _____ **Grade of School Completed:** _____

I live in a: ☐ House ☐ Apartment ☐ Condominium ☐ Mobile Home ☐ Boat

My home is: ☐ Single-Level ☐ Multi-Level # of stairs to enter: _____ # of stairs inside: _____

I live: ☐ Alone ☐ w/Spouse ☐ w/Parents ☐ w/Children Other _____

Alcohol Consumption:

Type: ☐ Beer ☐ Wine ☐ Whiskey ☐ None

Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

If you have quit, how long? _____

Tobacco Use:

Type: ☐ Cigarettes ☐ Pipe ☐ Chew ☐ None

How much used daily? _____

and for how long? _____

If you have quit, how long? _____

FAMILY HISTORY:

Mother: Living: YES or NO Age: _____ Condition of health: _____

If deceased, cause of death and age at death: _____

Father: Living: YES or NO Age: _____ Condition of health: _____

If deceased, cause of death and age at death: _____

Have you or any member of your family every had? (Indicate relative by placing a letter next to problem):
F-(father), **M**-(mother), **GF**-(grandfather), **GM**-(grandmother), **B**-(brother), **S**-(sister), **C**-(child), **U**-(uncle), **A**-(aunt)

- ☐ CANCER
- ☐ HEART ATTACK
- ☐ ARTHRITIS
- ☐ KIDNEY PROBLEMS
- ☐ EMPHYSEMA
- ☐ HIV/AIDS
- ☐ LUNG PROBLEMS
- ☐ ULCERS
- ☐ HIGH BLOOD PRESSURE
- ☐ DIABETES
- ☐ SEIZURES
- ☐ HEPATITIS
- ☐ COPD
- ☐ OSTEOPOROSIS
- ☐ BACK INJURY
- ☐ DEPRESSION
- ☐ HEART DISEASE
- ☐ STROKE
- ☐ TUBERCULOSIS (TB)
- ☐ ASTHMA
- ☐ LUPUS
- ☐ REACTION TO ANESTHESIA
- ☐ STOMACH PROBLEMS
- ☐ SKIN BREAKDOWN

SYMPTOM / SYSTEMS REVIEW:

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS**.

GENERAL HEALTH / CONSTITUTIONAL SYMPTOMS

- ☐ Fatigue
- ☐ Difficulty sleeping
- ☐ Unexplained bleeding
- ☐ Fever/chills
- ☐ Night sweats
- ☐ Recent weight change
- ☐ Other _____
- ☐ **NO PROBLEMS**

HEAD / FACE

- ☐ Headaches
- ☐ Lesions or scars
- ☐ Reduced facial strength
- ☐ Recent hair loss
- ☐ Masses
- ☐ Facial paralysis
- ☐ Scalp tenderness
- ☐ Other _____
- ☐ **NO PROBLEMS**

EYES

- ☐ Blurred or double vision
- ☐ Dryness
- ☐ Redness of the eyes
- ☐ Visual disturbances
- ☐ Wear glasses or contacts
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Other _____
- ☐ **NO PROBLEMS**

EARS / NOSE / MOUTH / THROAT

- ☐ Earaches or drainage
- ☐ Bad breath or bad taste
- ☐ Bleeding gums
- ☐ Hearing loss
- ☐ Mouth sores/ulcers
- ☐ Frequent sore throat
- ☐ Ringing in the ears
- ☐ Difficulty swallowing
- ☐ Voice changes
- ☐ Sinus infections/problems
- ☐ Sinus tenderness
- ☐ Dryness of the mouth
- ☐ Nosebleeds
- ☐ Hayfever
- ☐ Dentures
- ☐ Other _____
- ☐ **NO PROBLEMS**

NECK

- ☐ Masses
- ☐ Tenderness
- ☐ Thyroid tenderness
- ☐ Vein distention
- ☐ Swollen glands in the neck
- ☐ Pain
- ☐ Other _____
- ☐ **NO PROBLEMS**

CHEST / BREAST

- ☐ Breast discharge
- ☐ Breast implants
- ☐ Breast lump
- ☐ Breast pain
- ☐ Other _____
- ☐ **NO PROBLEMS**

CARDIOVASCULAR

- ☐ Chest pain or pressure
- ☐ Blood clots
- ☐ Swelling of feet and/or ankles
- ☐ Fast or irregular heart beat
- ☐ Palpitations
- ☐ Swelling of the hands
- ☐ Heart trouble
- ☐ Leg cramps
- ☐ Poor circulation
- ☐ Other _____
- ☐ **NO PROBLEMS**

RESPIRATORY

- ☐ Wheezing
- ☐ Chronic or frequent coughs
- ☐ Cough with mucous production
- ☐ Difficulty breathing
- ☐ Dry cough
- ☐ Shortness of breath when lying flat
- ☐ Shortness of breath when walking
- ☐ Pain on breathing
- ☐ Spitting/coughing blood
- ☐ Other _____
- ☐ **NO PROBLEMS**

SYMPTOM / SYSTEMS REVIEW (continued):

If you have ever experienced any of the following problems, please check the problem and write the year you experienced it right next to the checked item OR check **NO PROBLEMS**.

GASTROINTESTINAL

- ☐ Heartburn or indigestion
- ☐ Changes in bowel movements
- ☐ Rectal bleeding or blood in stool
- ☐ Painful bowel movements
- ☐ Constipation
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Abdominal pain
- ☐ Frequent diarrhea
- ☐ Stomach pain or cramps
- ☐ Other _____
- ☐ **NO PROBLEMS**

GENITOURINARY

- ☐ Burning or painful urination
- ☐ Blood or pus in urine
- ☐ Vaginal discharge
- ☐ Incontinence or dribbling
- ☐ Pain with periods
- ☐ Sexual difficulty
- ☐ Genital rash or ulcers
- ☐ Irregular periods
- ☐ Testicular pain
- ☐ Change in force of strain when urinating
- ☐ Prostate problems
- ☐ Other _____
- ☐ **NO PROBLEMS**

LYMPHATIC / HEMATOLOGIC

- ☐ Bleeding or bruising tendency
- ☐ Enlarged glands
- ☐ Phlebitis
- ☐ Slow to heal after cuts
- ☐ Other _____
- ☐ **NO PROBLEMS**

MUSULOSKELETAL / EXTREMITIES

- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty climbing stairs
- ☐ Difficulty walking
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Numbness or tingling
- ☐ Paralysis
- ☐ Walk with a limp
- ☐ Walk with assistive device
- ☐ Walk only limited distances
- ☐ Weakness of muscles or joints
- ☐ Other _____
- ☐ **NO PROBLEMS OTHER THAN REASON FOR VISIT**

NEUROLOGICAL / PSYCHIATRIC

- ☐ Convulsions or seizures
- ☐ Frequent/recurring headaches
- ☐ Numbness or tingling sensation
- ☐ Tremors
- ☐ Memory loss or confusion
- ☐ Light headed
- ☐ Loss of consciousness
- ☐ Feeling blue
- ☐ Dizziness
- ☐ Other _____
- ☐ **NO PROBLEMS**

INTEGUMENTARY / SKIN

- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Psoriasis
- ☐ Rash or itching
- ☐ Skin nodules or bumps
- ☐ Skin changes after sun exposure
- ☐ Other _____
- ☐ **NO PROBLEMS**

PLEASE LIST OTHER PERTINENT INFORMATION YOUR PHYSICIAN SHOULD KNOW:

_____

_____

_____

_____

_____

_____

_____

I hereby attest that I personally completed this form and all the information is true and correct.

_____ _____

Signature of Patient or Guardian completing form **Date**

HISTORY FORM REVIEWED BY: _____ DATE: _____

PHYSICIAN'S OR PHYSICIAN ASSISTANT'S SIGNATURE