

## PHYSICAL AND MEDICAL HISTORY

Date: \_\_\_\_\_

Age & DOB: \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Occupation: \_\_\_\_\_

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**Medications- \*\*including strength and directions\*\***


**Surgeries \*\*including date\*\***


**Drug Allergies \*\*including reaction\*\***


**Habits**

Exercise Routine: \_\_\_\_\_ Snoring: \_\_\_\_\_  
Caffeine (other than coffee): \_\_\_\_\_ Salt Intake: \_\_\_\_\_  
Difficulty falling asleep: \_\_\_\_\_ Daytime drowsiness: \_\_\_\_\_  
Fat intake: \_\_\_\_\_ Early morning awakening: \_\_\_\_\_  
Contact w/ blood/body fluid @ work: \_\_\_\_\_ History of drug abuse: \_\_\_\_\_

**Medical History**

Heart murmur: \_\_\_\_\_ Peripheral Vascular Disease: \_\_\_\_\_ Gallbladder Disease: \_\_\_\_\_  
Pneumonia: \_\_\_\_\_ Venereal Disease: \_\_\_\_\_ Hepatitis: \_\_\_\_\_ Osteoporosis: \_\_\_\_\_  
Ulcer: \_\_\_\_\_ Thyroid Disease: \_\_\_\_\_ Gout: \_\_\_\_\_ Rheumatic Fever: \_\_\_\_\_  
Prostate Disease: \_\_\_\_\_ Polio: \_\_\_\_\_ Mumps: \_\_\_\_\_ Measles: \_\_\_\_\_ Rubella: \_\_\_\_\_  
Diphtheria: \_\_\_\_\_ Tetanus: \_\_\_\_\_ Weight Change: \_\_\_\_\_

**Have you been hospitalized within the last year for any reason? \_\_\_\_\_**

**If yes, please provide place of hospitalization, illness, date & length of stay:**

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**NOTES**

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NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

### STUDY OF SYSTEMS

CONDITIONS	YES	NO	CONDITIONS	YES	NO	CONDITIONS	YES	NO
<b>*GENERAL*</b>			<b>*NECK*</b>			<b>*PSYCHOLOGICAL*</b>		
Fever			Stiffness			Is your life:		
Chills			Swelling			Satisfactory		
Bruise easily			Lumps			Boring		
Swollen glands			Other:*			Demanding		
Loss of memory			<b>*GASTROINTESTINAL*</b>			Unsatisfactory		
General weakness			Poor appetite			Is there worry over:		
Aches/Pains			Indigestion/Heartburn			Home life		
<b>*HEAD*</b>			Nausea			Marriage		
Double Vision			Vomiting blood			Job		
Light flashes			Abdominal pain or cramps			Children		
Blurred vision			Abdominal Tension			Money		
Halos around lights			Diarrhea			Do you:		
Eye pain			Constipation			Often feel depressed		
Ear pain			Changes in bowel habits			Have irrational fears		
Ear drainage			Rectum blood passage			Feel upset		
Buzzing/ringing in ears			Black/tarry bowel movements			Feel things often go wrong		
Nose bleeds			Other:*			Feel shy		
Sinus problems			<b>*KIDNEY*</b>			Cry easily		
Difficulty swallowing			Up nights to urinate			Feel inferior		
Deafness			Blood in urine			Have you:		
Mouth/Tooth/Tongue Problems			Burning/pain when urinating			Attempted suicide		
Persistent hoarseness			Problem passing urine			Seriously considered suicide		
Severe headaches			Trouble controlling urine			<b>*GENITALIA (MEN)*</b>		
Other:*			Other:*			Lump in testicles		
<b>*SKIN*</b>			<b>*NEUROMUSCULAR*</b>			Penis discharge		
Rash			Leg or arm weakness			Breast lump		
Changing moles			Balance problems			Sore(s) on penis		
Pigmentation			Dizziness			Erection difficulties		
Other:*			Fainting spells			Other:*		
<b>*HEART/CHEST/LUNGS*</b>			Speech problems			<b>*GENITALIA (WOMEN)*</b>		
Irregular heartbeat			Other:*			Breast lump(s)		
Shortness of breath			<b>*BONES/JOINTS*</b>			Nipple discharge		
Low exercise tolerance			Joint pain/swelling			Vaginal discharge		
Heart flutters			Muscle strength loss			Non-period bleeding/Spotting		
Chest pains			Muscle lump or swelling			Hot flashes		
Frequent coughs			Lump on bone			Pain w/ intercourse		
Coughing up blood			Pains in back			Possible pregnancy		
Wheezing			Other:*			Change in periods		
Night sweats			<b>*ENDOCRINE*</b>			Pain other than w/ periods		
Swollen Ankles			Constant thirst			Other:*		
Leg cramps			Cold intolerance			<b>*Explanation of 'Other'</b>		
Other:*			Heat intolerance					
<b>*Explanation of 'Other':</b>			Very sluggish/tired					
			Jumpy/Nervous					