NAME _____ **DATE** _____ **DOB**_____**AGE**_____

HAVE YOU HAD IN THE PAST:

DIABETES…… YES NO
HEART TROUBLE…….. YES NO
HIGH BLOOD PRESSURE…… YES NO
ASTHMA…… YES NO
LUNG TROUBLE…… YES NO
EPILEPSY…… YES NO
KIDNEY OR LIVER DISEASE..…… YES NO
DEPRESSION, PSYCHOLOGICAL …… YES NO
JAUNDICE…….. YES NO
BLEEDING TENDENCIES…….. YES NO
BLOOD CLOTS, PULMONARY EMBOLISM…… YES NO
STROKE OR WEAKNESS…….. YES NO
HAVE YOU HAD A BLOOD TRANSFUSION…… YES NO
EXPOSURE TO INFECTIONS DISEASE
(HIV, HEPATITIS, TUBERCULOSIS, ETC,)…… YES NO
WHICH: _____
ANY OTHER ILLNESSES YES NO
WHICH: _____

ANY FAMILY HISTORY OF DISEASE
(HIGH BLOOD PRESSURE, HEART DISEASE, PULMONARY EMBOLISM, DEEP VEIN THROMBOSIS, PHLEBITIS, DIABETES, CANCER, ETC.) YES NO
WHICH: _____
_____
_____

ANY ALLERGIES- (Medications, Latex, Tapes, etc.) YES NO
WHICH: _____
_____

DO YOU:

TAKE DRUGS OR MEDICATIONS
(ASPIRIN, VITAMINS, BIRTH CONTROL,HORMONES) YES NO

MEDICATION	**DOSE**	**HOW OFTEN?**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SMOKE…… YES NO
DRINK ALCOHOL…….. YES NO
OBJECT TO BLOOD TRANSFUSION…….. YES NO

HAVE YOU HAD:

ANY PREVIOUS HOSPITALIZATIONS……. YES NO
PREVIOUS SURGERY…… YES NO
WHAT SURGERY & DATES:
_____
_____
PREVIOUS INJURIES……. YES NO
WHAT INJURY & DATES:
_____
ARE YOU PREGNANT……. YES NO
LAST MENSTRUAL PERIOD _____
PULSE _____ BP_____
HT _____ WT_____

ARE YOU CURRENTLY EXPERIENCING:

EARS RECURRING EAR INFECTIONS HEARING LOSS…….. YES NO
EYES VISUAL PROBLEMS, DRY EYES, INFECTION, ALLERGY…… YES NO
THROAT SORES IN MOUTH OR THROAT, HOARSENESS, DIFFICULTY IN SWALLOWING, LUMP IN NECK…… YES NO
NOSE DIFFICULTY BREATHING THROUGH NOSE, BROKEN NOSE, ALLERGIES…. YES NO
LUNGS PNEUMONIA, COUGH, WHEEZING……. YES NO
HEART IRREGULAR HEARTBEAT, CHEST PAIN……. YES NO
BREAST LUMPS, PAIN…… YES NO
ABDOMEN ABDOMINAL PAIN, HEARTBURN, CONSTIPATION, DIARRHEA, BLOOD IN STOOLS…… YES NO
EXTREMITIES ARTHRITIS, JOINT PROBLEMS BROKEN BONES, UNUSUAL PAIN……. YES NO
NEURO EPILEPSY , HEADACHES, WEAKNESS NUMBNESS, DIZZINESS…….. YES NO
GU-GYN URINARY PROBLEM, PROSTATE, UTERUS, OVARIES…… YES NO

DOCTOR'S NOTES:

HEENT:
LUNGS:
HEART:
BREAST:
ABDOMEN:
EXTREMITIES:

Everything is included and correct on this history & physical regarding my health today **If anything changes, I will let you know.**

_____ _____ _____ _____ _____ _____
Patient Signature Witness Date Initial Witness Date