HISTORY AND PHYSICAL

NAME: _____ DATE: _____

AGE: _____ DOB: _____

Chief Complaint:

_____
_____
_____
_____
_____
_____
_____

History of Present Illness:

_____
_____
_____
_____
_____

Past Medical History:

_____
_____
_____
_____
_____
_____
_____
_____

Past Surgical History:

_____
_____
_____
_____

Family History:

_____
_____
_____
_____

Allergies:

_____
_____

Medications:

_____
_____
_____
_____
_____

Social History:
Smoking: ☐ yes ☐ no PPD: _____
Alcohol: ☐ yes ☐ no how often: _____
Drugs: ☐ yes ☐ no how often: _____
Comments:

_____
_____

Women Only:
Pregnant: ☐ yes ☐ no № of months: _____
Date of Last Menses: _____

Review of symptoms:

_____
_____
_____
_____
_____

OBSTRETRIC/GYNECOLOGICAL HISTORY (Women only)

Age that you started your period _____years old
Number of pregnancies _____
Age at first full term pregnancy _____years old

Is your period regular? □ Yes □ No □ N/A

Do/did you use birth control pills? □ Yes □ No
If yes, how long? _____

Have you had hysterectomy? □ Yes □ No
If yes, were the ovaries removed? □ Yes □ No

Age at menopause (if applicable) _____years old
Do/did you use estrogen hormone replacement therapy? □ Yes □ No
If yes, how long? _____

HEALTH MAINTENANCE

Have you had a sigmoidoscopy/colonoscopy? □ Yes, Date_____ □ No
Has your stool been checked for blood? □ Yes, Date_____ □ No
Have you had your skin checked? □ Yes, Date_____ □ No
Have you had an oral/dental exam? □ Yes, Date_____ □ No
Have you had a flu vaccination? □ Yes, Date_____ □ No

Women only:
Do you have regular PAP tests? □ Yes, Date_____ □ No
Do you examine your breasts regularly? □ Yes, Date_____ □ No
Have you had a DEXA scan? □ Yes, Date_____ □ No

Men only:
Do you examine your own testicles? □ Yes, Date_____ □ No
Do you have regular prostate exams? □ Yes, Date_____ □ No
Do you have regular PSA tests? □ Yes, Date_____ □ No

THIS FORM WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD

Patient's Signature _____ Date_____

MD Signature _____ Date _____