History & Physical

Name: ______

Name ______ SS# ______ Date ______

Address ______ Occupation ______

Phone (home) ______ (work) ______ Date of birth ______ Age ______

Chief complaint ______

DRUG ALLERGIES:

______

CURRENT MEDICATIONS:

______

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❒	❒	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	❒	❒
Stroke	❒	❒	❒	❒	❒	❒
Cancer	❒	❒	❒	❒	❒	❒
Glaucoma	❒	❒	❒	❒	❒	❒
Diabetes	❒	❒	❒	❒	❒	❒
Epilepsy / Convulsions	❒	❒	❒	❒	❒	❒
Bleeding Disorder	❒	❒	❒	❒	❒	❒
Kidney Disease	❒	❒	❒	❒	❒	❒
Thyroid Disease	❒	❒	❒	❒	❒	❒
Mental Illness	❒	❒	❒	❒	❒	❒
Osteoporosis	❒	❒	❒	❒	❒	❒

HOSPITALIZATION OR SURGERY:

Reason	Date	Reason	Date

MEDICAL HISTORY:

- ❒ Hypertension ______
- ❒ Hyperlipidemia ______
- ❒ Heart palpitations ______
- ❒ Heart murmur ______
- ❒ Arrhythmia ______
- ❒ Chest pain / Angina ______
- ❒ MI ______
- ❒ Stroke / TIAs ______
- ❒ Claudication ______
- ❒ Congestive heart failure ______
- ❒ Congenital heart disease ______
- ❒ Headache ______
- ❒ Epilepsy ______
- ❒ Dizziness/Fainting ______
- ❒ Anxiety ______
- ❒ Fatigue ______
- ❒ Shortness of breath ______
- ❒ Orthopnea ______
- ❒ Allergies / Hay fever ______
- ❒ Asthma ______
- ❒ COPD ______
- ❒ Pneumonia ______
- ❒ Venereal disease ______
- ❒ Scarlet fever ______
- ❒ Rheumatic fever ______
- ❒ Liver disease ______
- ❒ Ulcer ______
- ❒ GI Disorder ______
- ❒ Sexual dysfunction ______
- ❒ Menstrual dysfunction ______
- ❒ Incontinence ______
- ❒ Anemia ______
- ❒ Arthritis ______
- ❒ Osteoporosis ______
- ❒ Gout ______
- ❒ Diabetes ______
- ❒ Endocrinedisease ______
- ❒ Other ______
- ❒ Other ______

WOMEN ONLY:

Pregnant? ❒ Yes ❒ No Planning pregnancy? ❒ Yes ❒ No

MEN ONLY:

It's common for men to occasionally experience erection difficulties. Is this something that happens to you? ❒ Yes ❒ No

HABITS:

❒ Smoke: Packs daily ______
How long? ______
Interested in stopping? ______

❒ Exercise routine: ______

______

______

❒ Coffee: Cups daily ______
Other caffeine ______

❒ Alcohol: Type ______
Amount ______

❒ Diet: Salt intake ______
Fat intake ______

❒ Sleep: Difficulty falling asleep ______
Continuity disturbances ______
Snoring ______
Early morning awakening ______
Daytime drowsiness ______
Other ______