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History and Physical

Name: _____ DOB: _____ Chart: _____ Date: _____

Name of primary physician: _____

Referred by: _____

Reason for visit: _____

When was your last Pap? _____ Your last mammogram? _____

Review of Systems: *(Circle any of the following you have had and make any comments)*

Constitutional: (weight loss, weight gain, fever, tired/fatigue, pain) _____

Eyes: (visual changes, pain, light sensitivity, glasses/contacts) _____

ENT: (mouth, sinusitis, ringing in ears, nosebleeds, headaches, gum/mouth) _____

Cardiovascular: (chest pain, heart fluttering, leg swelling, short of breath w/activity) _____

Respiratory: (cough, wheezing, short of breath, coughing blood) _____

Gastrointestinal: (ulcers, pain, difficulty swallowing, diarrhea, constipation, bloody stools, heartburn, nausea) _____

Musculoskeletal: (joint pain, back pain, muscle weakness, muscle cramps) _____

Skin/Breast: (rash, breast discharge, pain, mass) _____

Neurological: (fainting, seizures, weakness, tingling) _____

Psychiatric: (depression, crying, anxiety, disturbed sleep) _____

Endocrine: (thirst, temperature intolerance, fatigue) _____

Hematologic: (bruises, bleeding, anemia, enlarged lymph nodes) _____

Immunology: (seasonal allergies, HIV, Chicken pox, Rubella, measles, mumps) _____

Genitourinary: (problems with urinating, urinary incontinence, urgency, frequency, frequent bladder infection, blood in urine, sexual dysfunction, vaginal discharge, vaginal irritation) _____

Personal Medical and Family History:

Have you or your family had any of the following problems? What medical problems do you have?
(M-Mother, F-Father, B-Brother, S-Sister, PGM-Paternal Grandmother, MGM-Maternal Grandmother, MA-Maternal Aunt, etc)

	You	Family	
Anemia	____	____	_____
Arthritis	____	____	_____
Asthma	____	____	_____
Bleeding: DVT/PE	____	____	_____
Blindness, hearing loss	____	____	_____
Bone fractures	____	____	_____
Breast disease	____	____	_____
Cancer	____	____	_____
Cholesterol, high	____	____	_____
Depression, anxiety	____	____	_____
Diabetes	____	____	_____
Eczema/Psoriasis	____	____	_____
Frequent bladder infections	____	____	_____
Gastric ulcers/GERD	____	____	_____
Glaucoma	____	____	_____
Headaches	____	____	_____
Heart disease/heart attack/mitrial valve prolapse	____	____	_____
Hemophilia	____	____	_____
Hepatitis, liver disease	____	____	_____
High blood pressure	____	____	_____
Irritable bowel, colitis	____	____	_____
Kidney disease	____	____	_____

Name: _____ DOB: _____ Chart: _____ Date: _____

(Personal Medical and Family History Continued)

	You	Family	
Mental illness	____	____	_____
Pneumonia	____	____	_____
Osteoporosis	____	____	_____
Seizures	____	____	_____
Stroke	____	____	_____
Thyroid disorder	____	____	_____
Tuberculosis	____	____	_____
Urinary incontinence	____	____	_____

Other medical problems: _____

_____

What surgeries have you undergone and when?

Year _____ Surgery _____
Year _____ Surgery _____
Year _____ Surgery _____
Year _____ Surgery _____
Year _____ Surgery _____
Year _____ Surgery _____

What illnesses or injuries have you had? *(hospitalizations, broken bones, diseases)*

_____

_____

Have you ever had a reaction to anesthesia? Describe: _____
Have your ever received a blood transfusion? _____ If so, why? _____

Social History:

Have you ever used: Cigarettes/tobacco? _____ #packs per day _____ for # years _____
Have you quit? _____ What year? _____
Alcohol? _____ Which? _____ #drinks per day/wk/mo _____
Street drugs? _____
Do you exercise regularly? _____
Describe your diet briefly: (food pyramid, junk food, etc.) _____

Are you: Single Married Divorced Widowed Separated Other _____
What is your occupation/homemaker? _____
Do you have any cultural or religious limitation? _____
What is the last grade or degree of education completed? _____
Do you feel safe where you live? Yes No _____

Allergies: List medication allergies and reactions:

Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____
Medication: _____ Reaction: _____

Medications: List medications and doses *(list vitamins and herbs also)*:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Name: _____ DOB: _____ Chart: _____ Date: _____

(Personal Medical and Family History Continued)

GYN History:

What was the first day of your last menstrual period? _____ Or menopause year? _____

What do you use for contraception? _____

How old were you at your first menstrual period? _____ Years

How often does your period occur, from start of one to start of the next (usual 28 days)? _____

How many days does your period usually last? _____

How old were you when you first had sexual intercourse? _____ Years

How many sexual partners have you had ever? _____

(Optional) What is your sexual orientation? Prefer: Men Other women Both

Have you ever had a sexually transmitted infection? (Chlamydia, gonorrhea, syphilis, herpes, HIV, trichomonas) _____

Have you ever had an abnormal Pap? _____ When? Comments _____

Have you ever had any procedures done on your cervix for an abnormal Pap (colposcopy/biopsy, cryotheraopy/freezing, LEEP/LLETZ, conization) _____ When? _____

Did your mother take DES when pregnant with you? _____

Are you planning on becoming pregnant? _____

Have you ever been in an abusive relationship? _____

How old were you at your first delivery? _____

Have you ever been on contraceptives? _____ How many years _____ Which? _____

Have you ever been on any hormones? _____ How many years _____ Which? _____

Have you ever been diagnosed with: (endometriosis, fibroids, PID/infections), other: _____

Obstetric History:

How many times have you been pregnant altogether? _____

Have you ever had (year, how many): abortion ___ early miscarriage ___ ectopic ___ stillborn ___

Any D & C's done for pregnancies? _____ What year? _____

Deliveries: (Note: 40 weeks is normal gestation)

#	Year	Wks gestation	Hours in labor	Type (vag, C/S)	Baby wt	M/F	Complications
1.							
2.							
3.							
4.							
5.							
6.							