Patient Name: _____ Date of Birth:_____

Date of Surgery:_____ Medical Record #: _____

Temp: _____ BP: _____
Ht: _____ P: _____
WT: _____ R: _____

NEW PATIENT HISTORY AND PHYSICAL FORM

Patient's Name:	**Age:**	**Sex:** ☐ Male ☐ Female
CHIEF COMPLAINT: (why you are here today)		

History of Present Illness

- **LOCATION** of pain / problem?
- **HOW LONG** have you had this problem?
- **HOW OFTEN** do you have the pain?
- What makes it **WORSE**?
- What makes it **BETTER**?
- What **ASSOCIATED PROBLEMS** have you been having?
- What is the **severity** of your pain? Mar an **X** on the appropriate circle below:

  (No Pain) ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ (Extreme Pain)
- What does the pain **FEEL** like? (throbbing, shooting, sharp, etc.)

General Medical Information

My General Health Is: (please check one) ☐ Excellent ☐ Very Good ☐ Good ☐ Fair

Who is your family Doctor: _____

Are you currently pregnant or attempting to get pregnant? ☐ Yes ☐ No

List any medications you are currently taking including strength and how often taken:

Name	Dosage	How Often

Name	Dosage	How Often

Are you currently taking (or have you taken in the past) diet pills or herbal supplements? ☐ Yes ☐ No

If Yes, what is the name of the pill/supplement and the date last taken: _____

_____

Patient Name: _____ Date of Birth:_____

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Allergies

List any Medications and/or foods that you are ALLERGIC to or have had a bad reaction to:

Medication / Food	Reaction

Name	Reaction

Past Medical History

Check any problem that you have ever been treated for:

- ☐ Alcohol Dependency
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Infection
- ☐ Bleeding Tendencies
- ☐ Blood Transfusion
- ☐ Bowel Obstruction
- ☐ Broken Bones
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemotherapy
- ☐ Cirrhosis
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Dependency
- ☐ Emphysema
- ☐ Fainting Spells
- ☐ Gall Stones
- ☐ Glaucoma
- ☐ Gout
- ☐ Headaches
- ☐ Head Injury
- ☐ Hepatitis ○ A ○ B ○ C
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Hereditary Defects
- ☐ Hiatal Hernia / Reflux
- ☐ HIV / AIDS
- ☐ Hypertension
- ☐ Insomnia
- ☐ Irregular Heartbeat
- ☐ Jaundice
- ☐ Kidney Disease/Failure
- ☐ Lupus
- ☐ Muscle Weakness
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Paralysis
- ☐ PVD
- ☐ Pneumonia
- ☐ Polio
- ☐ Recent URI
- ☐ Rheumatoid Arthritis
- ☐ Ruptured Disc
- ☐ Sciatica
- ☐ Seizures
- ☐ Sickle Cell Anemia
- ☐ Significant Weight Loss/Gain
- ☐ Spinal Curvature
- ☐ Steroid Use
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Syncope
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Urinary Retention
- ☐ UTI
- ☐ Valvular Disease
- ☐ Varicose Veins
- ☐ Venereal Disease

Surgical / Hospitalization History

Type of Surgery	Date of Surgery

Patient Name: _____ Date of Birth:_____

Date of Surgery:_____ Medical Record #: _____

Prior Non-Surgical Hospitalizations, Major Illnesses or Injuries

Reson ofr Admit	Date of Admit

Social History

Occupation: _____ Marital Status: ☐ S ☐ M ☐ W ☐ Dv ☐ Sp

Are you working now? ☐ Yes ☐ No If no, when did you last work? _____

Place of Birth: _____ Grade of School Completed: _____

I Live in a: ☐ House ☐ Apartment ☐ Condominium ☐ Mobil Home ☐ Boat

Alcohol Consumption:

Type: ☐ Beer ☐ Wine ☐ Hard Liquor ☐ None Have you quit? ☐ Yes ☐ No
Frequency: ☐ Daily ☐ Weekly ☐ Monthly ☐ Never If Yes, How long? _____

Tobacco Use:

Type: ☐ Cigarettes ☐ Pipe ☐ Chew ☐ None Have you quit? ☐ Yes ☐ No
How much used daily? _____
For how long?_____ If Yes, How long? _____

Family History

Mother: Living: ☐ Yes ☐ No Age: _____ Condition of Health: _____

If Deceased, cause of death and age of death:_____

Father: Living: ☐ Yes ☐ No Age: _____ Condition of Health: _____

If Deceased, cause of death and age of death:_____

Have you or any member of your family ever had any of the following? (indicate relative by placing a letter next to the problem)
F - Father, **M** - Mother, **GF** - Grandfather, **GM** - Grandmother, **B** - Brother, **S** - Sister, **C** – Child, **U** - Uncle, **A** - Aunt

	Cancer		High Blood Pressure		Heart Disease
	Heart Attack		Diabetes		Stroke
	Arthritis		Seizures		Tuberculosis (TB)
	Kidney Problems		Hepatitis		Asthma
	Emphysema		COPD		Lupus
	HIV / AIDS		Osteoporosis		Reaction to Anesthesia
	Lung Problems		Back Injury		Stomach Problems
	Ulcers		Depression		Skin Breakdown

Patient Name: _____ Date of Birth:_____

Date of Surgery:_____ Medical Record #: _____

Symptom / Systems Review

GENERAL HEALTH/ CONSTITUTIONAL SYMPTOMS
☐ Fatigue
☐ Difficulty Sleeping
☐ Unexpected Bleeding
☐ Fever / Chills
☐ Night Sweats
☐ Other _____
☐ **NO PROBLEMS**

HEAD / FACE
☐ Headaches
☐ Lesions or Scars
☐ Reduced Facial Strength
☐ Recent Hair Loss
☐ Masses
☐ Facial Paralysis
☐ Scalp Tenderness
☐ Other _____
☐ **NO PROBLEMS**

EYES
☐ Blurred or Double Vision
☐ Dryness
☐ Redness of the Eyes
☐ Visual Disturbances
☐ Wear Glasses or Contacts
☐ Cataracts
☐ Glaucoma
☐ Other _____
☐ **NO PROBLEMS**

GASREOINTESTINAL
☐ Heartburn or Indigestion
☐ Changes in Bowel Movements
☐ Rectal Bleeding or Blood in the Stool
☐ Painful Bowel Movements
☐ Constipation
☐ Loss of Appetite
☐ Nausea or Vomiting
☐ Abdominal Pain
☐ Frequent Diarrhea
☐ Stomach Pain or Cramps
☐ Other _____
☐ **NO PROBLEMS**

NEUROLOGICAL / PSYCHIATRIC
☐ Convulsions or Seizures
☐ Frequent / Recurring Headaches
☐ Numbness or Tingling Sensation
☐ tremors
☐ Memory Loss or Confusion
☐ Light Headed
☐ Loss of Consciousness
☐ Feeling Blue
☐ Dizziness
☐ Other _____
☐ **NO PROBLEMS**

EARS / NOSE / MOUTH / THROAT
☐ Earaches or Drainage
☐ Bad Breath or Bad Taste
☐ Bleeding Gums
☐ Hearing Loss
☐ Mouth Sores / Ulcers
☐ Frequent Sore Throat
☐ Ringing in the Ears
☐ Difficulty Swallowing
☐ Voice Changes
☐ Sinus Infections / Problems
☐ Sinus Tenderness
☐ Dryness of the Mouth
☐ Nosebleeds
☐ Hayfever
☐Dentures
☐ Other _____
☐ **NO PROBLEMS**

NECK
☐ Masses
☐ Tenderness
☐ Thyroid Tenderness
☐ Vein Distention
☐ Swollen Glands in the Neck
☐ Pain
☐ Other _____
☐ **NO PROBLEMS**

MUSCULOSKELETAL / EXTREMITIES
☐ Back Pain
☐ Cold Extremities
☐ Difficulty Climbing Stairs
☐ Difficulty Walking
☐ Joint Pain
☐ Joint Stiffness or Swelling
☐ Numbness or Tingling
☐ Paralysis
☐ Walk with a Limp
☐ Walk with Assistive Device
☐ Walk Only Limited Distances
☐ Weakness of Muscles or Joints
☐ Other _____
☐ **NO PROBLEMS**

GENITOURINARY
☐ Burning or Painful Urination
☐ Blood or Puss in Urine
☐ Vaginal Discharge
☐ Incontinence or Dribbling
☐ Pain with Periods
☐ Sexual Difficulty
☐ Genital Rash or Ulcers
☐ Irregular Periods
☐ Testicular Pain
☐ Change in Force of Strain Urinating
☐ Prostate Problems
☐ Other _____
☐ **NO PROBLEMS**

CHEST / BREAST
☐ Breast Discharge
☐ Breast Implants
☐ Breast Lump
☐ Breast Pain
☐ Other _____
☐ **NO PROBLEMS**

CARDIOVASCULAR
☐ Chest Pain or Pressure
☐ Blood Clots
☐ Swelling of Feet and/or Ankles
☐ Fast or Irregular Heartbeat
☐ Palpitations
☐ Swelling of the Hands
☐ Heart Trouble
☐ Leg Cramps
☐ Poor Circulation
☐ Other _____
☐ **NO PROBLEMS**

RESPIRATORY
☐ Wheezing
☐ Chronic or Frequent Coughs
☐ Cough with Mucous Production
☐ Difficulty Breathing
☐ Dry Cough
☐ Shortness of Breath when lying Flat
☐ Shortness of Breath when Walking
☐ Pain on Breathing
☐ Spitting / Coughing up Blood
☐ Other _____
☐ **NO PROBLEMS**

LYMPHATIC / HEMATOLOGIC
☐ Bleeding or Bruising Tendency
☐ enlarged Glands
☐ Phlebitis
☐ Slow to Heal After Cuts
☐Other _____
☐ **NO PROBLEMS**

INTEGUMENTARY / SKIN
☐ Change in Skin Color
☐ Change in Hair or Nails
☐ Psoriasis
☐ Rash or Itching
☐ Skin Nodules or Bumps
☐ Skin Changes After Sun Exposure
☐ Other
☐ **NO PROBLEMS**

Patient Name: _____ Date of Birth:_____

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Please list any other pertinent information that your physicians should know:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby attest that I personally completed this form and all information contained herein is true and correct.

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name of Patient or Responsible Party

HISTORY & PHYSICAL FORM REVIED BY: _____ DATE:_____

Print Name of Physician or Physician Assistant

SIGNATURE OF PHYSICIAN OR PHYSICIAN ASSISTANT: _____