

History & Physical

Why are you seeing the doctor today? _____

What caused it? _____

Is the current problem a result of a (n): (check all that apply)

Car Accident Work Accident Other _____

When did it begin? Month _____ Day _____ Year _____ *(Your insurance requires a specific date)*

Are you right or left handed? (circle one or both)

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

	Circle	Describe all Yes Responses		No	Yes
Eyes	No	Yes _____	Balance problems	No	Yes _____
Ears, Nose	No	Yes _____	Numbness/tingling	No	Yes _____
Lungs/Breathing	No	Yes _____	Blackout/fainting	No	Yes _____
Digestion	No	Yes _____	Psychological problem	No	Yes _____
Bowels	No	Yes _____	AIDS	No	Yes _____
Bladder	No	Yes _____	Cancer	No	Yes _____
Diabetes	No	Yes _____	Arthritis	No	Yes _____
Blood Pressure	No	Yes _____	Polio	No	Yes _____
Bleeding Prob	No	Yes _____	TB	No	Yes _____
Blood Clots	No	Yes _____	Epilepsy	No	Yes _____
			Stroke	No	Yes _____

Past Surgical History: (Please List Surgeries)

1. _____ Doctor _____ Date _____
2. _____ Doctor _____ Date _____
3. _____ Doctor _____ Date _____
4. _____ Doctor _____ Date _____
5. _____ Doctor _____ Date _____

Medicines

What medications are you taking, both prescription and non prescription

1. _____
2. _____
3. _____
4. _____
5. _____

You May Use Back of Paper for More Meds

Are you ALLERGIC to any medicine? Do you have any other allergies?

Social History

Do you use tobacco? _____ How much? _____ How long? _____

Do you use alcohol? _____ How much? _____ How long? _____

What is your occupation? _____

I have filled out all information to the best of my knowledge; I understand that I am responsible for my medical information and that any omission of medical information has the potential to have an adverse reaction to my medical care.

Patient Signature: _____ Date: _____

Reviewed By: _____ MD Date: _____

Reviewed By: _____ MD Date: _____

Reviewed By: _____ MD Date: _____

PAST MEDICAL HISTORY

Do you have other health problems (such as High blood pressure, diabetes, heart disease, etc?)

Have you ever been hospitalized? If so, for what, and when? Please list below

