



INITIAL PATIENT HISTORY & PHYSICAL

This form is to help your doctor give you better health care.
It is completely confidential and will be part of your medical record.
PLEASE MAKE SURE YOU COMPLETE ALL *THREE* PAGES

M.D. _____

Today's _____ Acc't _____

Date _____ No. _____

Patient Name _____ D.O.B _____

Address _____

_____ Nickname _____

Home _____ Work _____
Phone _____ Phone _____

Lifetime _____ Retired Yes
Occupation _____ No

Employer _____

WHICH PHYSICIAN REFERRED YOU TO US?

PLEASE LIST ANY OTHER PHYSICIANS TO WHOM YOU
WOULD LIKE COPIES OF INFORMATION SENT:

Name _____ Address /City/State _____ Problems Cared For _____

YOUR PHARMACY:

Name _____

Address _____

Phone _____

List of Allergies: _____

LATEX ALLERGY Yes No

MARITAL STATUS:

Single Married Widowed

Separated Divorced

LIVING ARRANGEMENT:

Alone With Spouse/ Significant Other

Supervised Living Other _____

SERVICES IN YOUR HOME:

None Aide Nurse Meals on Wheels

Home Care Agency Name _____

Other _____

PLEASE CHECK BOXES FOR ITEMS THAT YOU HAVE:

Organ Donor Card Health Care Proxy Living Will

Power of Attorney

Would you like more information on any of these? Yes No

Information Given: _____

LIST A PERSON WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU:

Name _____

Address _____

Home _____ Work _____

Phone _____ Phone _____

Relationship _____

PERSON COMPLETING THIS FROM IF OTHER THAN PATIENT

REASON FOR SEEING DOCTOR: >

LIST ALL MEDICATIONS YOU NOW TAKE (Including Non-Prescription Medications And Herbal Remedies)			FAMILY HISTORY:	Present Age	Age at Death	Present Health or Cause of Death
Medication	Dose	Times Daily				
			Father			
			Mother			
			<input type="checkbox"/> Brother <input type="checkbox"/> Sister			
			<input type="checkbox"/> Brother <input type="checkbox"/> Sister			
			<input type="checkbox"/> Brother <input type="checkbox"/> Sister			
			<input type="checkbox"/> Brother <input type="checkbox"/> Sister			
			<input type="checkbox"/> Brother <input type="checkbox"/> Sister			
			Spouse			
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
			<input type="checkbox"/> Son <input type="checkbox"/> Daughter			

DO ANY OTHER MEMBERS OF YOUR FAMILY HAVE A HISTORY OF CANCER OR BLOOD DISORDER? IF YES, PLEASE EXPLAIN

DO YOU NOW OR HAVE YOU EVER	LIST YEAR YOU LAST HAD	FOR WOMEN ONLY	
		Smoked Cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Pkgs/Day _____ #Yrs. When Quit _____ Consumed Alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Drinks/Wk _____ When Quit _____ Consumed Coffee/ Tea? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ Cups/ Day _____ Used Street/ Illegal Drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____	Flu Vaccine _____ Hepatitis Vaccine _____ T.B. Test (PPD) _____ Stool Blood Test _____ Eye Exam _____ Cholesterol Test: _____ (result) _____ Tetanus Shot _____ Pneumonia shot _____ Rectal Exam _____ Sigmoid Exam _____ Dental Exam _____

MEDICAL HISTORY Answer these history questions by checking the appropriate boxes. If you want to discuss any answer with the doctor, also circle the box.

HAVE YOU EVER HAD:

- A Heart Condition High Blood Pressure
- A Stroke
- A Lung Disorder
- Stomach / Gall Bladder Problems
- Jaundice / Hepatitis / other Liver Disorders
- Ulcerative Colitis / Crohn's Disease
- Kidney / Bladder Problems
- Sexual Problems
- A.I.D.S
- Venereal Disease / Herpes
- Arthritis / Chronic Pain
- Frequent Headaches / A Nervous Disorder
- Seizure Disorder
- Depression / Anxiety
- A Thyroid Problem
- Diabetes
- Skin Diseases (Eczema / Psoriasis / Hives)
- Breast / Prostate Problems
- Anemia / Blood Problems
- A Blood Transfusion
- Cancer
- Allergies / Drug Sensitivities
- Asthma / Hives
- Birth Defects / Inherited Diseases
- Chicken Pox
- Measles / Mumps / Rubella
- Other Medical Problems:
- No Known Medical Problems**

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HOSPITALIZATIONS Please list those operations of serious illness that you have had which required hospitalization. If you have had more than four, check this box.
Do not include pregnancies here

PRIOR CANCER TREATMENT

Mo./Yr.	Illness or Operation	Complications		Mo./Yr.	Radiation Site	Chemo Type	Where Treated
		Yes	No				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				
		<input type="checkbox"/>	<input type="checkbox"/>				

ARE YOU **CURRENTLY**
EXPERIENCING ANY OF THE
FOLLOWING?
CHECK **ALL** THAT APPLY.

CONSTITUTIONAL

- No problems or concerns
- Recent weight loss
- Recent weight gain
- Fevers / Chills
- Night sweats
- Excessive itching
- Food supplements
- On a diet now *Type* _____
- _____ Number of meals daily

EYES

- No problems or concerns
- Glaucoma
- Cataracts
- Vision loss
- Other: _____

EAR, NOSE, MOUTH, THROAT

- No problems or concerns
- Hearing loss
- Dental problem
- Hoarseness
- Nose bleeds
- Other: _____

CARDIOLOGY

- No problems or concerns
- High blood pressure
- Heart murmur
- Rapid / Irregular heartbeat
- Chest pain / Tightness
- Pacemaker / Defibrillator
- Ankle swelling
- Leg cramps at night
- Other: _____

RESPIRATORY

- No problems or concerns
- Asthma / Bronchitis / Emphysema
- Shortness of breath
- Cough that produces blood
- Other: _____

GASROINTESTINAL

- No problems or concerns
- Loss of appetite
- Heartburn or indigestion
- Stomach pain or discomfort
- Frequent nausea / Vomiting
- Recurrent diarrhea / Constipation
- Bloody stools
- Black, tarry stools
- Difficulty swallowing
- Other: _____

(Please do not forget to complete
right side column)

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GENITOURINARY

- No problems or concerns
- Difficulty urinating
- Frequent / Painful urination
- Recurrent bladder infection
- Vaginal itching / Discharge
- Sexual problems
- Blood in urine
- Other: _____

MUSCULOSKELETAL

- No problems or concerns
- Difficulty walking
- Joint aches or stiffness
- Painful legs / Feet
- Back ache / Pain
- Other: _____

NEUROLOGIC

- No problems or concerns
- Difficulty concentrating
- Headache
- Dizziness / Fainting / Blackouts
- Numbness hands / Feet
- Seizures / Convulsions
- Memory changes
- Other: _____

PSYCHOSOCIAL

- No problems or concerns
- Nightmares
- Anxious / Nervous
- Trouble sleeping
- Lonely / Depressed
- Work / Family problems
- Tire easily
- Other: _____

ENDOCRINE

- No problems or concerns
- Thyroid problems
- Blood sugar problems
- Excessive sweating
- Other: _____

SKIN / BREAST

- No problems or concerns
- Sores / Rashes
- Moles
- Nipple discharge
- Change in breast size
- Lump / Pain
- Other: _____

HEMATOLOGIC / LYMPHATIC

- No problems or concerns
- Easy bleeding / Bruising
- Anemia or blood problem
- Frequent infections
- Swelling of glands
- Swelling of hands / Feet
- Other: _____

ALLERGIC / IMMUNOLOGIC

- No problems or concerns
- Facial swelling
- Tightening of throat
- Hives
- Other: _____

M.D. Signature

Date