

FAMILY PRACTICE

HISTORY AND PHYSICAL

Name SS # Date
 Address Occupation
 Phone (Home) (Work) Birth Date
 Spouse or Partner Phone (Home) (Work)
 Childrens Names
 Chief complaint

DRUG ALLERGIES

FAMILY HISTORY

CURRENT MEDS

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITALIZATION OR SURGERY

Reason Date Reason Date

WOMEN ONLY Pregnant? Yes No Planning Pregnancy? Yes No

PAST MEDICAL HISTORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Lactose intolerance | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Bowel irregularity | <input type="checkbox"/> Chronic rashes |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Sexual/Menstrual dysfunction | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Allergies/Hay fever | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> GI disorder | <input type="checkbox"/> Nervousness | |

HABITS

- | | | |
|---|---|-------------------------|
| <input type="checkbox"/> Smoke: Packs daily | How long | When stopped |
| <input type="checkbox"/> Exercise routine: | <input type="checkbox"/> Coffee: Cups daily | Other caffeines |
| <input type="checkbox"/> Alcohol: Type / Amount | Diet: Salt intake | Fat intake |
| <input type="checkbox"/> SLEEP: Difficulty falling asleep | Continuity disturbances | Early morning awakening |
| Snoring | Daytime drowsiness | |
| <input type="checkbox"/> Contact with blood or body fluid at work | | |