HISTORY AND PHYSICAL

PAST MEDICAL HISTORY: Have you ever had the following: (Circle "no" or "yes")

HABITS:

Do you smoke now? ☐no ☐yes Number of packages per day? _____Number of years you have smoked? _____
Have you ever smoked? ☐no ☐yes I quit _____ years ago.
Do you drink alcohol? ☐no ☐yes Amount per week? _____ I quit _____ years ago.

Have you ever had the following: (Circle "no" or "yes")

Arthritis	no	yes	Heart disease	no	yes	Epilepsy	no	yes
Diabetes	no	yes	Tuberculosis	no	yes	Hemorrhoids	no	yes
Cancer	no	yes	Venereal disease	no	yes	Glaucoma	no	yes
Blood or plasma transfusion	no	yes	Migraine headaches	no	yes	Bladder infections	no	yes
Hernia	no	yes	Asthma	no	yes	Back trouble	no	yes
AIDS or HIV+	no	yes	High or low blood pressure	no	yes	Bronchitis	no	yes
Hives or eczema	no	yes	Stroke	no	yes	Mitral valve prolapse	no	yes
Ulcer	no	yes	Hepatitis	no	yes	Thyroid disease	no	yes
Kidney disease	no	yes	Pneumonia	no	yes	Bleeding tendency	no	yes

Date of last chest x-ray: _____
Date of last EKG: _____
Please list any other diseases not included above:_____
_____

FAMILY HISTORY: Has any **member of your immediate family** had any of the following:

(Circle "no" or "yes")

			Relationship				Relationship
Cancer	no	yes	_____	Stroke	no	yes	_____
Tuberculosis	no	yes	_____	Epilepsy	no	yes	_____
Diabetes	no	yes	_____	Allergies	no	yes	_____
Heart disease	no	yes	_____	Anemia	no	yes	_____
High blood Pressure	no	yes	_____	Bleeding tendency	no	yes	_____
Asthma	no	yes	_____	Chronic lung disease	no	yes	_____
Drug abuse	no	yes	_____	Alcohol abuse	no	yes	_____
Mental illness	no	yes	_____	Leukemia	no	yes	_____
Migraines	no	yes	_____	Obesity	no	yes	_____
Thyroid disease	no	yes	_____	Ulcer	no	yes	_____
Depression	no	yes	_____	High cholesterol	no	yes	_____
Kidney disease	no	yes	_____	Glaucoma	no	yes	_____
Gout	no	yes	_____				

List family members below with age, or age at death. If living, list present state of health. If deceased, list the cause of death:

Father _____
Mother _____
Brothers and Sisters_____
Spouse_____
Children_____

REVIEW OF SYSTEMS: Do you have now or have you had within the past month any of the following: (Circle "no" or "yes")

Weakness or paralysis	no	yes	Muscle cramps or spasms	no	yes	Tire easily or weak	no	yes	Backaches	no	yes
Recent weight change	no	yes	Swollen joints	no	yes	Change in appetite	no	yes	Chest pains	no	yes
Sensitivity to cold	no	yes	Palpitations/fluttering heart	no	yes	Persistent fever	no	yes	Leg cramps	no	yes
Night sweats	no	yes	Enlarged veins	no	yes	Skin rash	no	yes	Heartburn	no	yes
Skin trouble or changes	no	yes	Frequent belching	no	yes	Headaches	no	yes	Nausea	no	yes
Change in nails or hair	no	yes	Abdominal cramping	no	yes	Vomiting	no	yes	Eye pain	no	yes
Easy bleeding	no	yes	Double vision	no	yes	Blurred vision	no	yes	Vomited blood	no	yes
Chronic diarrhea	no	yes	Infected eyes	no	yes	Chronic constipation	no	yes	Glasses/contacts	no	yes
Rectal bleeding	no	yes	Black tarry stools	no	yes	Ringing in the ears	no	yes	Dark urine	no	yes
Yellow jaundice	no	yes	Ear pain	no	yes	Hemorrhoids	no	yes	Seizures	no	yes
Decrease in hearing	no	yes	Frequent nosebleeds	no	yes	Memory loss	no	yes	Frequent colds	no	yes
Dizziness	no	yes	Sinus trouble	no	yes	Sleeplessness	no	yes	Loss of Smell	no	yes
Depression	no	yes	Persistent hoarseness	no	yes	Poor coordination	no	yes	Sore throat	no	yes
Frequent urination (day)	no	yes	Sore tongue and gums	no	yes	Frequent urination	no	yes	Chronic cough	no	yes
Increase in thirst	no	yes	Shortness of breath	no	yes	Painful urination	no	yes	Bloody sputum	no	yes