History & Physical

Name	Date
Name of Primary Physician	MD Phone number
Date of last visit to primary physician?	MD Address
Purpose of visit to primary physician?	

Family History	Name	Age	If Deceased, Cause of Death	Age at Death	Has any family member ever had:		Who?
Father					Alcoholism	Yes No	
Mother					Cancer	Yes No	
Siblings	1.				Goiter	Yes No	
	2.				Tuberculosis	Yes No	
	3.				Diabetes	Yes No	
	4.				Heart Trouble	Yes No	
	5.				High Blood Pressure	Yes No	
	6.				Stroke	Yes No	
Spouse					Epilepsy	Yes No	
Children	1.				Neurological Disorder	Yes No	
	2.				Suicide	Yes No	
	3.				Kidney Disease	Yes No	
	4.				Asthma	Yes No	
	5.				Emphysema	Yes No	

Medical History

Have you ever had any of the following: (Please circle (NO) or (Now) or (Past) (what year?)

Rheumatic Fever?	No Now Past ( )		When was your last physical examination?
Epilepsy?	No Now Past ( )		What medications are you allergic to?
Tuberculosis?	No Now Past ( )		Have you ever had any major illnesses requiring hospitalization, surgery, fractures, major dental problems or head injuries?
Nervousness?	No Now Past ( )		Have you had any complications from childhood diseases?
Mental Problem?	No Now Past ( )		Has sleep been a problem?
Arthritis?	No Now Past ( )		Has sex been a problem?
Bone / Joint Disease?	No Now Past ( )		Have you had any changes in appetite?
Meningitis?	No Now Past ( )		What was your weight one year ago?
Venereal Disease?	No Now Past ( )		What is your weight now?
Anemia?	No Now Past ( )		Have you had any difficulty concentrating?
Jaundice/ Hepatitis?	No Now Past ( )		What activities do you do for fun?

Thyroid?	No Now Past ( )		**What time of the day do you feel best?**
Diabetes?	No Now Past ( )		**Do you have any physical complaints at present?**
Cancer?	No Now Past ( )		
High Blood Pressure?	No Now Past ( )		**If you have seen a therapist in the past, what were you treated for?**
Heart Disease?	No Now Past ( )		
Asthma?	No Now Past ( )		
Stroke?	No Now Past ( )		

What Medications do you take on a regular basis?

Medication	Dosage	# times daily	Prescribed by?

System History

Have you had any of the following: (Please circle your response?)

Eye Disease, Injury, Impairment	No	Yes	**Night sweats**	No	Yes
Ear Disease, Injury, Impairment	No	Yes	**Shortness of breath**	No	Yes
Trouble with Nose, sinuses, throat or mouth	No	Yes	**Palpitations or fluttering heart**	No	Yes
Head Injuries	No	Yes	**Swelling of hands, feet or ankles**	No	Yes
Fainting Spells	No	Yes	**Back, arm or leg problems**	No	Yes
Loss of Consciousness	No	Yes	**Varicose Veins**	No	Yes
Convulsions	No	Yes	**Kidney Disease or stones**	No	Yes
Paralysis	No	Yes	**Bladder Disease**	No	Yes
Dizziness	No	Yes	**Albumin, pus or blood in urine**	No	Yes
Frequent or severe headaches	No	Yes	**Difficulty urinating**	No	Yes
Depression or anxiety	No	Yes	**Abnormal thirst**	No	Yes
Difficulty concentrating	No	Yes	**Stomach trouble or ulcer**	No	Yes
Memory Problems	No	Yes	**Indigestion**	No	Yes
Extreme tiredness or weakness	No	Yes	**Appendicitis**	No	Yes
Hallucinations	No	Yes	**Liver or gallbladder disease**	No	Yes

Enlarged Glands	No	Yes	**Colitis or bowel disease**	No	Yes
Enlarged Thyroid or Goiter	No	Yes	**Hemorrhoids or rectal bleeding**	No	Yes
Skin Disease	No	Yes	**Constipation or diarrhea**	No	Yes
Chronic or frequent cough	No	Yes	**Crying Spells**	No	Yes
Chest pain or angina	No	Yes	**Suicidal thoughts**	No	Yes
Coughing up blood	No	Yes	**Loss of Appetite**	No	Yes

Habits

Do you smoke cigarettes, pipe or cigar?	Which?	How much?
Do you drink caffeinated beverages?	Coffee?	How much?
	Tea?	How much?
	Colas?	How much?

Has alcohol use ever been a problem?
Have you ever been in treatment for alcoholism?

Have you ever used recreational (street) drugs? Which? How often?
During what period of time?
When was the last time you used any drug?

Have you ever been treated for a drug problem?

Are you currently seeking treatment because of an alcohol or drug problem?

Women Only; Menstrual History

Age of first menses? ________

Cycle length ________ (days from first day of one menses to the first day of next menses)

Duration ________ (days from start to end)

Date of Last Period? ________

# of pregnancies? ________

Miscarriages? ________

Abortions? ________

Children? ________

Military History

Branch ______________________________________

Rank at Discharge ____________________________

When did you serve? __________________________