

HISTORY AND PHYSICAL FORM

Patient Name: _____ Date of Birth: _____

Preferred Pharmacy: _____ Phone# _____

Reason for Being Seen Today: _____

Medication List

Name of Medication	Dose/Frequency	Name of Medication	Dose/Frequency

Medical History (check all that apply):

Disease	Date	Disease	Date	Disease	Date	Disease	Date
Arthritis		Gall bladder		Hiatal Hernia		Pulmonary Embolism	
Asthma		Glaucoma / Cataracts		High Cholesterol		Stroke/ TIA	
Cancer		Gout		Hypertension		Tuberculosis	
CHF/ CAD		Heart Attack		Kidney Disease		Thyroid	
DVT/ Deep Vein Thrombosis		Heart Failure		Obstructive Sleep Apnea		Ulcers	
Diabetes		Heart Murmur		Pacemaker		Varicose Veins	
Emphysema		Hepatitis		Peripheral Artery Disease		Other:	

Allergies? _____ Latex Allergy? Yes / No

Prior Surgeries, Hospitalizations, or Orthopedic Procedures

Type of Surgery or Procedure	Hospital	Date

Family History

(Heart Disease, Heart Attack, Stroke, Hypertension, High Cholesterol, Coronary Artery Disease, Kidney Disease, Diabetes, Cancer, etc.)

Mother		Deceased?	Yes / No
Father		Deceased?	Yes / No
Children		Deceased?	Yes / No
Siblings		Deceased?	Yes / No

Do You Smoke? Yes/ No How Much? _____ Former Smoker? Yes / No Year Quit: _____

Do You Drink Alcohol? Yes / No Frequency? _____

Height _____ Weight _____

Review of Systems (check all that you are currently experiencing):

CONSTITUTIONAL		EYES		ENT	
☐	Fever / Chills	☐	Blurred vision	☐	Ear pain or hearing loss
☐	Generalized weakness	☐	Loss of vision	☐	Ulcers in the mouth
☐	Headaches	☐	Eye pain	☐	Painful/difficult to swallow
CARDIOVASCULAR		NEUROLOGICAL		ENDOCRINE	
☐	Chest pain / Palpitations	☐	Headaches	☐	Diabetes
☐	CABG/ CAD/ CHF	☐	Dizziness/ weakness	☐	Thyroid
☐	Aneurysm	☐	Balance issues	☐	Excessive hunger/thirst
GENITOURINARY		INTEGUMENTARY		PSYCHIATRIC	
☐	Enlarged prostate	☐	Rash/itching	☐	Anxiety
☐	Blood in urine	☐	Ulcers/ wounds	☐	Depression
☐	Painful/frequent urination	☐	Hair or nail changes	☐	
PERIPHERAL VASCULAR		GASTROINTESTINAL		MUSCULOSKELETAL	
☐	Leg cramps/ swelling	☐	Bloody stool / rectal bleed	☐	Arthritis
☐	Foot pain at night	☐	Nausea & vomiting	☐	Joint pain/stiffness
☐	Redness/ open wounds	☐	Weight changes	☐	Difficulty walking
☐	Coldness in extremities	☐	History of GI Bleed	☐	
RESPIRATORY		ANY OTHER INFORMATION YOU FEEL WE SHOULD KNOW:			
☐	Asthma				
☐	COPD/ emphysema				
☐	Obstructive Sleep Apnea				
☐	Snoring				
☐	SOB				

Patient Signature: _____ Date: _____