

## **Patient History and Physical Form**

Name	DOB			DOS					
Occupation									
DRUG ALLERGIES		FAMILY HISTORY							
		Fath		Mother	F Parents	M Parents	Siblings	Children	
		Heart Disease							
	High Blood Pressure								
	Stroke								
	Cancer								
CURRENT MEDICATIONS	Glauco								
	Diabetes								
	Epilepsy/Convulsions								
	Bleeding Disorder								
	Kidney Disease Thyroid Disease								
	Mental Illness								
	Osteoporo								
		Озісорогозіз							
		HOSPITILIZATI	IONS OR S	URGERIES					
Reason		Date		Reason		Date			
WOMEN	I ONLY: Pregnant?	Vos	No P	lanning Pro	anancy?	Vos	No		
Date of Last PAP Smear				□ Yes □ N			_ NO vide copy of	results	
Onset of Period		,				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
How many pregnancies? How many births? How many miscarriages?									
		MEDIC	CAL HISTOI	RY					
☐ Anxiety ☐ Asthma ☐ Cancer (type:				) □ Depression					
☐ Diabetes	☐ Hay Fever ☐ Gout				sease/Murmu	r ☐ High Blood Pressure			
□ Dizziness/Fainting	□ Allergies □ Bronchitis			☐ Periphera	al Vascular D	isease			
☐ GI Disorder	☐ Venereal Disease ☐ Hepatitis			□ Anemia		☐ Arthritis			
☐ Osteoporosis	☐ Stroke ☐ Kidney Dis		sease	☐ Thyroid □		☐ Mental Illness			
☐ Other (please specify)			☐ Sleep Apnea						
Immunizations: (please spe	cify)					· · · · · · · · · · · · · · · · · · ·	····		
			HABITS						
□ Smoke packs daily □ Coffee cups of			,						
How long?	☐ Other Caffeine								
When stopped?	<del></del>								
<ul><li>☐ Chewing Tobacco</li><li>☐ Exercise Routine</li></ul>	ne Fat Intake						☐ Wheel Chair/Walker		
LYGICI36 LOUTING	——— □ Rec Dr			<del> </del>		- AALICGI	o iaii/ vvaikei		
☐ Contact with blood or be		•							
Do you have a Living Will?	Yes □	No I	Do you hav	e a DNR?	□ Yes □ N	О			