INITIAL PATIENT HISTORY & PHYSICAL

This form is to help your doctor give you better health care.
It is completely confidential and will be part of your medical record.
PLEASE MAKE SURE YOU COMPLETE ALL *THREE* PAGES

M.D. _____
Today's Date _____ Acc't No. _____

Patient Name _____ D.O.B _____

Address _____

_____ Nickname _____

Home Phone _____ Work Phone _____

Lifetime Occupation _____ Retired ☐ Yes ☐ No

Employer _____

WHICH PHYSICIAN REFERRED YOU TO US?

_____

PLEASE LIST ANY OTHER PHYSICIANS TO WHOM YOU WOULD LIKE COPIES OF INFORMATION SENT:

Name Address /City/State Problems Cared For

_____

_____

_____

_____

YOUR PHARMACY:

Name _____

Address _____

Phone _____

List of Allergies: _____

_____

LATEX ALLERGY ☐ Yes ☐ No

MARITAL STATUS:

☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

LIVING ARRANGEMENT:

☐ Alone ☐ With Spouse/ Significamt Other
☐ Supervised Living ☐ Other _____

SERVICES IN YOUR HOME:

☐ None ☐ Aide ☐ Nurse ☐ Meals on Wheels
☐ Home Care Agency Name _____
☐ Other _____

PLEASE CHECK BOXES FOR ITEMS THAT YOU HAVE:

☐ Organ Donor Card ☐ Health Care Proxy ☐ Living Will
☐ Power of Attorney

Would you like more information on any of these? ☐ Yes ☐ No

Information Given: _____

LIST A PERSON WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU:

Name _____

Address _____

_____

Home Phone _____ Work Phone _____

Relationship _____

PERSON COMPLETING THIS FROM IF OTHER THAN PATIENT

REASON FOR SEEING DOCTOR:

LIST ALL MEDICATIONS YOU NOW TAKE
(Including Non-Prescription Medications And Herbal Remedies)

Medication	Dose	Times Daily

FAMILY HISTORY:

	Present Age	Age at Death	Present Health or Cause of Death
Father			
Mother			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
☐ Brother ☐ Sister			
Spouse			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			
☐ Son ☐ Daughter			

DO ANY OTHER MEMBERS OF YOUR FAMILY HAVE A HISTORY OF CANCER OR BLOOD DISORDER? IF YES, PLEASE EXPLAIN

_____

_____

DO YOU NOW OR HAVE YOU EVER	LIST YEAR YOU LAST HAD	FOR WOMEN ONLY
Smoked Cigarettes? ☐ Yes ☐ No _____Pkgs/Day____#Yrs. When Quit___ Consumed Alcohol? ☐ Yes ☐ No _____ Drinks/Wk When Quit___ Consumed Coffee/ Tea? ☐ Yes ☐ No _____Cups/ Day Used Street/ Illegal Drugs? ☐ Yes ☐ No *Type* _____	_____ Flu Vaccine _____ Hepatitis Vaccine _____ T.B. Test (PPD) _____ Stool Blood Test _____ Eye Exam _____ Cholesterol Test: *(result* *)* _____ Tetanus Shot _____ Pneumonia shot _____ Rectal Exam _____ Sigmoid Exam _____ Dental Exam	Age at *First* Menstrual Period ____ Date of *Last* Period _____ Have you ever taken birth control pills? ☐ Yes ☐ No How Long? ____Yrs. Do you now use birth control? ☐ Yes ☐ No *Type* _____ Have you *ever* taken hormone replacements? ☐ **Yes** ☐ **No** How Long? ___ Yrs. Are you currently taking hormone replacements? ☐ Yes ☐ No Number of Pregnancies ____ Number of Live Births____ Age at 1st Childbirth ____ Year of Last: _____ Pap Test ☐ Normal ☐ Abnormal _____ Breast Exam ☐ Normal ☐ Abnormal _____ Mammogram ☐ Normal ☐ Abnormal

MEDICAL HISTORY Answer these history questions by checking the appropriate boxes. If you want to discuss any answer with the doctor, also circle the box. **HAVE YOU *EVER* HAD:**	For Office Use Only
☐ A Heart Condition ☐ High Blood Pressure	
☐ A Stroke	
☐ A Lung Disorder	
☐ Stomach / Gall Bladder Problems	
☐ Jaundice / Hepatitis / other Liver Disorders	
☐ Ulcerative Colitis / Crohn's Disease	
☐ Kidney / Bladder Problems	
☐ Sexual Problems	
☐ A.I.D.S	
☐ Venereal Disease / Herpes	
☐ Arthritis / Chronic Pain	
☐ Frequent Headaches / A Nervous Disorder	
☐ Seizure Disorder	
☐ Depression / Anxiety	
☐ A Thyroid Problem	
☐ Diabetes	
☐ Skin Diseases (Eczema / Psoriasis / Hives)	
☐ Breast / Prostate Problems	
☐ Anemia / Blood Problems	
☐ A Blood Transfusion	
☐ Cancer	
☐ Allergies / Drug Sensitivities	
☐ Asthma / Hives	
☐ Birth Defects / Inherited Diseases	
☐ Chicken Pox	
☐ Measles / Mumps / Rubella	
☐ Other Medical Problems:	
☐ **No Known Medical Problems**	

HOSPITALIZATIONS Please list those operations of serious illness that you have had which required hospitalization. If you have had more than four, check this box . ☐
Do not include pregnancies here

PRIOR CANCER TREATMENT

Mo./Yr.	Illness or Operation	Complications Yes	Complications No	Mo./Yr.	Radiation Chemo Site Type	Where Treated
		☐	☐			
		☐	☐			
		☐	☐			
		☐	☐			

ARE YOU ***CURRENTLY*** EXPERIENCING ANY OF THE FOLLOWING?
CHECK ***ALL*** THAT APPLY.

CONSTITUTIONAL

- ☐ No problems or concerns
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Fevers / Chills
- ☐ Night sweats
- ☐ Excessive itching
- ☐ Food supplements
- ☐ On a diet now *Type* _____ _____ Number of meals daily

EYES

- ☐ No problems or concerns
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Vision loss
- ☐ Other: _____

EAR, NOSE, MOUTH, THROAT

- ☐ No problems or concerns
- ☐ Hearing loss
- ☐ Dental problem
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Other: _____

CARDIOLOGY

- ☐ No problems or concerns
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Rapid / Irregular heartbeat
- ☐ Chest pain / Tightness
- ☐ Pacemaker / Defibrillator
- ☐ Ankle swelling
- ☐ Leg cramps at night
- ☐ Other: _____

RESPIRATORY

- ☐ No problems or concerns
- ☐ Asthma / Bronchitis / Emphysema
- ☐ Shortness of breath
- ☐ Cough that produces blood
- ☐ Other: _____

GASROINTESTINAL

- ☐ No problems or concerns
- ☐ Loss of appetite
- ☐ Hearburn or indigestion
- ☐ Stomach pain or discomfort
- ☐ Frequent nausea / Vomiting
- ☐ Recurrent diarrhea / Constipation
- ☐ Bloody stools
- ☐ Black, tarry stools
- ☐ Difficulty swallowing
- ☐ Other: _____

(Please do not forget to complete right side column)

Office Use Only

M.D. Signature Date

GENITOURINARY

- ☐ No problems or concerns
- ☐ Difficulty urinating
- ☐ Frequent / Painful urination
- ☐ Recurrent bladder infection
- ☐ Vaginal itching / Discharge
- ☐ Sexual problems
- ☐ Blood in urine
- ☐ Other: _____

MUSCULOSKELETAL

- ☐ No problems or concerns
- ☐ Difficulty walking
- ☐ Joint aches or stiffness
- ☐ Painful legs / Feet
- ☐ Back ache / Pain
- ☐ Other: _____

NEUROLOGIC

- ☐ No problems or concerns
- ☐ Difficulty concentrating
- ☐ Headache
- ☐ Dizziness / Fainting / Blackouts
- ☐ Numbness hands / Feet
- ☐ Seizures / Convulsions
- ☐ Memory changes
- ☐ Other: _____

PSYCHOSOCIAL

- ☐ No problems or concerns
- ☐ Nightmares
- ☐ Anxious / Nervous
- ☐ Trouble sleeping
- ☐ Lonely / Depressed
- ☐ Work / Family problems
- ☐ Tire easily
- ☐ Other: _____

ENDOCRINE

- ☐ No problems or concerns
- ☐ Thyroid problems
- ☐ Blood sugar problems
- ☐ Excessive sweating
- ☐ Other: _____

SKIN / BREAST

- ☐ No problems or concerns
- ☐ Sores / Rashes
- ☐ Moles
- ☐ Nipple discharge
- ☐ Change in breast size
- ☐ Lump / Pain
- ☐ Other: _____

HEMATOLOGIC / LYMPHATIC

- ☐ No problems or concerns
- ☐ Easy bleeding / Bruising
- ☐ Anemia or blood problem
- ☐ Frequent infections
- ☐ Swelling of glands
- ☐ Swelling of hands / Feet
- ☐ Other: _____

ALLERGIC / IMMUNOLOGIC

- ☐ No problems or concerns
- ☐ Facial swelling
- ☐ Tightening of throat
- ☐ Hives
- ☐ Other: _____