Patient History & Physical

Today's Date: ____________________

Name of Patient: ____

Sex: ☐ Male ☐ Female **Date of Birth:** ____________________

Home Phone Number: ____________________ **Work Phone Number:** ____________________

Name of Insurance Company: ____

Are prescriptions covered?: ☐ Yes ☐ No

Reason for today's visit? ____

<u>Medical History:</u> (☐ None)

☐ Allergies/Hayfever	☐ Glaucoma	☐ Diabetes
☐ Asthma	☐ Wear Glasses/Contacts	☐ Kidney Stones
☐ Anemia	☐ Hearing Problems	☐ Kidney Disease
☐ Blood Disorder	☐ Dentures	☐ Seizure Disorder
☐ Depression	☐ Neck/Back Pain	☐ Arthritis
☐ Anxiety	☐ Thyroid Disease	☐ Gout
☐ Panic Attacks	☐ Heartburn	☐ Acne
☐ Sleeping Problems	☐ Emphysema	☐ Skin Disease:
☐ Problems with Anger	☐ Tuberculosis	____________________
☐ Memory Loss	☐ Chronic Bronchitis	☐ Heart Disease:
☐ High Blood Pressure	☐ Diverticulosis	____________________
☐ Fatigue	☐ Crohn's Disease	☐ Cancer:
☐ Eating Disorder	☐ Ulcerative Colitis	____________________
☐ Drug/Alcohol Abuse	☐ Diarrhea/Constipation	☐ Sexually Transmitted Disease:
☐ Stroke	☐ Liver Disease	____________________
☐ Other: ____________________	☐ Other: ____________________	☐ Other: ____________________

Surgeries/Hospitalizations: (☐ None)

____

Patient Label

Physicians & Surgeons Clinic

426310 (4/07)

Patient History & Physical (Pg 2)

Social History:

Marital Status: ☐M ☐S ☐W ☐D Educational Level: ________________ Occupation: ______________________

☐ **Smoking** _____________ Packs per day. _________ Years Quit Date: ____________

☐ **Alcohol** _____________ Drinks per day. _________ Years Quit Date: ____________

☐ **Recreational Drugs:** (List Type) ____

☐ **Caffeine:** ☐ Coffee ☐ Tea ☐ Pop Amount per Day: ________________________________

☐ **Multiple Sexual Partners:** Number: ______________ Currently Sexually Active? ☐ Yes ☐ No

☐ **I have a Living Will/Advance Directive**

☐ **Religious Preferences:** ____

Family History: (☐ None) **KEY:** M=Mother F=Father S=Brother/Sister GF=Grandfather GM=Grandmother C=Child

Please use the above key to show who in your family has/had the disease; list after the diseases specified below.

	Disease	Who in Family?		Disease	Who in Family?
☐	Arthritis	______________	☐	High Blood Pressure	______________
☐	Asthma/Allergies	______________	☐	Kidney Disease	______________
☐	Birth Defects/Inherited Disease	______________	☐	Lung Disease	______________
☐	Blood Disorders	______________	☐	Mental Illness	______________
☐	Bowel Problems	______________	☐	Skin Disease	______________
☐	Cancer	______________	☐	Stroke	______________
☐	Diabetes	______________	☐	Thyroid Disease	______________
☐	Epilepsy/Seizures	______________	☐	Tuberculosis	______________
☐	Glaucoma	______________	☐	Ulcers	______________
☐	Gout	______________	☐	Other:____________________	______________
☐	Headaches/Migraines	______________	☐	Other:____________________	______________
☐	Heart Disease	______________	☐	Other:____________________	______________

Current Medications: (☐ None)

Name of Medication	Dose	How Often?	Name of Medication	Dose	How Often?

Drug Allergies: (☐ None)

Date	Drug	Reaction

Immunizations:

☐ Measles ☐ Rubella ☐ Pertussis ☐ Polio ☐ Chicken Pox ☐ Flu

☐ Mumps ☐ Diptheria ☐ Tetanus ☐ Hepatitis ☐ Pneumonia ☐ Other: ____________

Patient History & Physical (Pg 3)

Female History: (☐ Not Applicable)

Age at first menstrual period: ______ Flow: ☐Heavy ☐Moderate ☐Light Day of Flow _____ Cycle Length _____

Number of: Pregnancies_____ Live Births _____ Miscarriages _____ Elective Abortions _____ Living Children _____

Date of last menstrual period: ________________ **Birth Control Method:** ____________________________________

Abnormal vaginal discharge: ☐ Yes ☐ No If Yes, describe: _______________________________________

____

Review of System: (Please indicate if you have any of the following)

☐ Blood Transfusion	☐ Shortness of Breath	☐ Headaches / Migraines
☐ Chicken Pox	☐ Wheezing	☐ Fainting Spells
☐ Rheumatic Fever	☐ Chronic Cough / Bronchitis	☐ Confusion / Memory Loss
☐ Undesired Weight Loss	☐ Coughing up Blood	☐ Muscle Weakness
☐ Sweats	☐ Bloody or Black Stools	☐ Moodiness
☐ Fatigue	☐ Hemorrhoids	☐ Sleeping Difficulty
☐ Changes in Vision	☐ Changes in Bowel Habits	☐ Nervousness
☐ Wear Glasses or Contacts	☐ Diarrhea	☐ Difficulty Concentrating
☐ Eye Problems	☐ Constipation	☐ Hot Flashes
☐ Ear Infections	☐ Swallowing Difficulty	☐ Hot or Cold Intolerance
☐ Dizziness	☐ Heartburn / Acid Reflux	☐ Excessive Thirst or Urination
☐ Dentures	☐ Gallbladder or Liver Problems	☐ Enlarged Thyroid Gland
☐ Recurrent Nose Bleeds	☐ Persistent Nausea / Vomiting	☐ Recurrent Bleeding or Easy Bruising
☐ Hearing Problems	☐ Recurrent Abdominal Pain	☐ Excessive Sneezing
☐ Voice Changes	☐ Painful or Frequent Urination	☐ Watering Eyes
☐ Sinus Problems	☐ Pain with Intercourse	☐ Constant Runny Nose
☐ Chest Pain	☐ Loss of Bladder Control	☐ Reaction to Bee Stings
☐ Heart Murmur	☐ Bladder Infections	☐ Breast Tenderness
☐ Leg Pain with Walking	☐ Skin Disorder	☐ Sexual Problems
☐ Varicose Veins	☐ Hives / Itching	☐ Recent Stressful Life Event:
☐ Swollen Ankles	☐ Muscle / Joint / Bone Pain	____________________________
☐ Poor Circulation	☐ Broken Bones _________________	☐ Other: ______________________

Tests and Procedures: (Please indicate most recent approximate date.) (☐ None)

Test	Approx. Date	Test	Approx. Date
☐ Flexible Sigmoidoscopy / Colonoscopy	___________	☐ Dental Exam	___________
☐ Stool Test (for blood)	___________	☐ Hearing Test	___________
☐ Rectal Exam	___________	☐ Eye Exam	___________
☐ Prostate Test (PSA)	___________	☐ Chest X-Ray	___________
☐ Exercise Stress Test	___________	☐ EKG	___________
☐ Pap Smear / Pelvic Exam	___________	☐ TB Test	___________
☐ Mammogram	___________	☐ Blood Work	___________
☐ Cholesterol	___________	☐ Other: _________________________	___________

Which of the above tests have ever been *abnormal*? Please explain below.

____

____

Is there anything else you think I should know? ____

Physician Signature ____

Patient Label

WEST VALLEY HOSPITAL

Physicians & Surgeons Clinic