SMH Physicians Network

HISTORY AND PHYSICAL FORM

Patient Name _____ Date of Birth _____

Reason for visit: _____

Referred by: _____

ALLERGIES

List medications and/or foods that you are ALLERGIC to or have had a bad reaction to:

_____

What kind of reaction did you have?

_____

PAST MEDICAL HISTORY

	YES Ongoing	YES Past	NO		YES Ongoing	YES Past	NO
Allergies				GERD			
Anemia				Glaucoma			
Anxiety				Heart murmur			
Arthritis				HIV/AIDS			
Asthma				Hyperlipidemia			
Artrial fibrillation				Hypertension			
Blood transfusion				Hyperthyroidism			
Cancer				Kidney disease			
Cataracts				Meningitis			
CHF				Myocardial infarction			
Clotting Disorder				Nerve / muscle disease			
COPD				Osteoporosis			
Coronary artery disease				Pulmonary embolism			
Deep Vein Thrombosis				Seizures			
Dementia				Sickle cell anemia			
Depression				Stomach ulcers			
Diabetes mellitus type 1				Stroke			
Diabetes mellitus type 2				Substance abuse			
Emphysema				Thyroid disease			
				Tuberculosis			

SURGICAL HISTORY

	YES	NO		YES	NO
Adenoidectomy			Fracture surgery		
Appendectomy			Hernia repair		
Brain surgery			Hysterectomy		
Breast surgery			Joint replacement		
CABG			Kidney transplant		
Cholecystectomy			Small intestine surgery		
Colon surgery			Spine surgery		
Colonoscopy			Tonsillectomy		
Cosmetic surgery			Tubal ligation		
C-Section			Valve replacement		
Eye surgery					

FAMILY HISTORY

Mother: Condition of health: Good Stable Poor Deceased: Age at Death: _____Cause of Death:_____

Father: Condition of health: Good Stable Poor Deceased: Age at Death: _____ Cause of Death:_____

Has any member of your family ever had? (Indicate relative by placing an X next to problem):

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
No Known Problems						
Alcohol abuse						
Arthritis						
Asthma						
Birth defects						
Cancer (type)						
COPD						
Depression						
Diabetes						
Drug abuse						
Early death						
Hearing loss						
Heart disease						
Hyperlipidemia						
Hypertension						
Kidney disease						
Learning disability						
Mental Illness						
Mental retardation						
Miscarriages						
Stroke						
Vision loss						

SOCIAL HISTORY

Alcohol Use? Yes or No What?_____ How Often?_____

Sexually Active: Yes or No Birth Control / Protection: _____

Drug Use? Yes or No What? _____ How Often? _____

Tobacco Use? (Circle all that apply) Current Former Everyday Some Days Never Pipe Chew

How much? _____ Quit: When? _____

Have you traveled within the last 30 days? If so, where? _____

HEALTH MAINTENANCE

Prostate Exam: YES/NO Date: _____ Doctor's name_____

Colonoscopy: YES/NO Date: _____ Doctor/Facility _____

Stool Sample: (Circle One) Fecal Occult or Cologuard Date _____Doctor/Facility_____

Pap Smear: YES/NO Date: _____ Doctor/Facility_____

Mammogram: YES/NO Date: _____ Doctor/Facility _____

Diabetic Foot Exam YES/NO Date: _____ Doctor/Facility _____

Last flu shot: _____ Last tetanus shot: _____ Last Tdap shot: _____

Last Pneumonia shot: _____Last shingles shot: _____ Last eye exam: _____

Do you have any mental impairments/handicaps? YES _____ NO _____ if so, please list _____

MEDICATIONS

List any medications you are currently taking.

Medication Name: Strength? How Often? What for? Who prescribed?

_____

_____

_____

_____

_____

_____

_____

_____

PREFERRED LOCAL PHARMACY

Name: _____

Address: _____

Phone: _____

Do you receive your medication(s) through the mail? YES / NO

If yes, what pharmacy? _____