**HISTORY AND PHYSICAL** (Please complete carefully and completely) **TODAY'S DATE**_____

NAME_____ AGE _____BIRTH DATE _____
HEIGHT_____ WEIGHT_____
REFERRING PHYSICIAN_____ PRIMARY PHYSICIAN _____

**REVIEW OF SYSTEMS** (Mark any of these symptoms you may have had within the past year)

GENERAL: ☐ Poor appetite ☐ weight change
HEAD: ☐ Headaches
EYES: ☐ Blurred vision ☐ Double vision
THROAT: ☐ Chronic sore throats ☐ Difficulty swallowing
LUNGS: ☐ Shortness of breath ☐ Chronic cough
MOUTH: ☐ Loose teeth ☐ False teeth ☐ Dental problems
HEME: ☐ Easy bruising ☐ Easy bleeding tendency

HEART: ☐ Chest pain ☐ Heart pounding ☐ Swollen ankles ☐ Swollen hands
ABDOMEN: ☐ Nausea ☐ Vomiting ☐ Change in bowel habits ☐ Blood in stool ☐ Recurrent indigestion ☐ Abdominal pain ☐ Diarrhea ☐ Constipation
GU: ☐ Frequent urination ☐ Pain or burning with urination

****HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION?** ☐ **YES** ☐ **NO**

**PAST MEDICAL HISTORY**: (Mark if you have ever had any of the following)

- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots in Legs
- ☐ Blood Clots in Lungs
- ☐ Bowel Disease
- ☐ Breast Cysts or Lumps
- ☐ Cancer _____
- ☐ Chronic Bronchitis
- ☐ Depression
- ☐ Diabetes Adult/Child
  - ☐ Insulin Dependent
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Hard of Hearing
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia-Hiatal/Other
- ☐ High Blood Pressure
- ☐ High Cholesterol/Triglycerides
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease/COPD
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Nervous Breakdown
- ☐ Pneumonia
- ☐ Polio
- ☐ Poor Vision
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Skin Disease
- ☐ Sleep Apnea
- ☐ Thyroid Problem
- ☐ Tuberculosis
- ☐ Ulcers
- Other _____

**CARDIAC HISTORY**
Have you ever been treated for a heart problem? ☐ YES ☐ NO
Name and Number of Cardiologist_____ Last EKG_____

**FAMILY HISTORY**

| | Maternal | Paternal |
|---|---|---|
| Blood Disease | ☐ | ☐ |
| Heart attack | ☐ | ☐ |
| Coronary artery disease | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ |
| Problems with anesthesia | ☐ | ☐ |
| Lung Disease | ☐ | ☐ |
| Birth Defects | ☐ | ☐ |
| Liver Disease | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ |

**SOCIAL HISTORY**

Do you smoke cigarettes? ☐ YES ☐ NO
Packs/Day _____ ☐ E-cigarettes/vape pen
Are you willing to quit smoking? ☐ YES ☐ NO
Previous smokers, when did you stop? _____
Do you chew tobacco? ☐ YES ☐ NO
Do you use drugs? ☐ YES ☐ NO
Do you drink alcohol? ☐ YES ☐ NO
Have you ever taken Cortisone? ☐ YES ☐ NO
Any problems with Anesthesia? ☐ YES ☐ NO
Are you ☐ **LEFT** or ☐ **RIGHT** handed?
History of drug or alcohol abuse? ☐ YES ☐ NO
Do you use marijuana? ☐ YES ☐ NO

**LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING**
Name/Strength/Frequency

_____
_____
_____
_____
_____

**LIST ALL KNOWN ALLERGIES/REACTION**

_____
_____
_____
_____
_____
_____

**LIST ALL MAJOR SURGERIES AND INJURIES**

| DATE | SURGERIES | DATE | INJURIES |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |