History & Physical Patient Name_____ DOB_____

Past Medical History *check all that apply. Describe details of medical conditions in spaces below.*			
☐ Allergies	☐ BPH(Enlarged Prostate)	☐ Diabetes(Circle Type **1** or Type **2**)	☐ Migraine
☐ Anemia	☐ Blood Clots	☐ Heartburn	☐ Osteoporosis
☐ Hepatitis (Circle **A** or **B**)	☐ Angina	☐ Cancer_____	☐ HIV/AIDS
☐ Anxiety	☐ CVA (Stroke)	☐ High Cholesterol	☐ Kidney Disease
☐ Arthritis	☐ COPD (Emphysema)	☐ High Blood Pressure	☐ Seizures
☐ Asthma	☐ Crohn's Disease	☐ IBS	☐ Thyroid Disease
☐ Atrial Fibrillation	☐ Depression	☐ Liver Disease	
☐ Other			☐ ***Check Box if none apply***

Past Surgical History *check all that apply. Describe details of medical conditions in spaces below.*			
☐ Appendectomy	☐ Gastric Bypass	☐ Small Bowel Surgery	☐ Hysterectomy
☐ Angioplasty	☐ Groin Hernia Repair	☐ Thyroid Surgery	☐ Mastectomy
☐ Breast Reduction	☐ Arthroscopy knee	☐ Hip replacement	☐ Tonsillectomy
☐ Back Surgery	☐ Knee Replacement	☐ Ovaries Removed	☐ Carpal Tunnel
☐ Breast Implants	☐ Vasectomy	☐ Tubes Tied	☐ Cataract
☐ Liver Biopsy	☐ Breast Biopsy	☐ Prostate Biopsy	☐ D&C
☐ Gallbladder Removal	☐ Hip Repair Fracture	☐ Colon Surgery	☐ Pacemaker
☐ C-Section	☐ TURP(Prostate Surgery)	☐ LASIK	
☐ Other			☐ ***Check Box if none apply***

Family Medical History	**Father**	**Mother**	**Father's Parents**	**Mother's Parents**	**Siblings**	**Children**
Heart Disease	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
☐ ***Check Box if none apply***						

Do you have frequent urges to urinate?	☐ Yes ☐ No
How often do you urinate during the day?	
How often do you wake up at night to urinate?	
Do you experience leaking accidents?	☐ Yes ☐ No
Do you have Erection problems *Men Only*	☐ Yes ☐ No
How often does this occur?	☐ Frequently ☐ Sometimes ☐ Rarely

History & Physical Patient Name_____ DOB_____

Women's Health History			
Age of first menstrual period?		Are you currently pregnant?	Yes No Possibly
Age of first birth?		Date of last Mammogram	
Beginning date of last menstrual period		Date of last Pap smear?	
If you have achieved menopause	What age?	What year?	Natural or Surgical (circle)

Pregnancy History *list the number of each type in space*

Full term	Premature	C-Section	Vaginal	Live birth	Ectopic	Miscarriage	Abortion

Medications *include over the counter medications and supplements* ☐ **Check box if NO Medications**

Drug name	Dosage Strength	How Many times a Day
1		
2		
3		
4		
5		
6		
7		
8		

Allergies ☐ **Check box if NO Allergies**

Drug Name/Drug Class/Food	Reaction
1	
2	
3	
4	

Habits

Smoke	Packs daily:	How Long: Interested in stopping?
Coffee	Cups daily:	Other Caffeine:
Alcohol	Type:	Amount:
Diet	Salt intake:	Fat intake:
Sleep	Difficulty sleeping ☐ Yes ☐ No	Continuity disturbances ☐ Yes ☐ No Snoring ☐ Yes ☐ No
	Early morning awakening ☐ Yes ☐ No	Daytime drowsiness ☐ Yes ☐ No
Exercise	Type:	

Preferred Local Pharmacy	**Mail In Pharmacy**	
Name	☐ Medco	☐ Prime Mail
Location	☐ Express Scripts	☐ Prescriptions
Phone	☐ Right source	☐ CVS/Caremark
Fax	Other:	

Provider Signature_____ **Date**_____