

# Autumn Road Family Practice

## HISTORY & PHYSICAL

Date \_\_\_\_\_

Name _____	M <input type="checkbox"/> F <input type="checkbox"/>	Circle Status: S M W D SEP	DOB: _____	Age: _____
Address _____	Phone (H) _____	(W) _____	(C) _____	
E-mail address _____				

**Previous or Referring Physician:** \_\_\_\_\_ **Pharmacy:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

### PERSONAL HISTORY

Are you up to date on these screening tests/exams? Please give month/year of last one:

Exam	Year	Exam	Year
Bone Density Testing		Physical Exam with Labs	
Colonoscopy		Pneumonia Shot	
EKG		Prostate Exam	
Flu Shot		Pap Smear	
Mammogram		Tetanus Shot	
Other Immunizations:			

Have you ever been diagnosed with any of the following conditions? If so, when and who treated the condition?

Condition	Yes	No	Year	Treating Provider	Condition	Yes	No	Year	Treating Provider
Anemia/Bleeding Disorder					HIV/Aids				
Anxiety/Depression					High Cholesterol				
Other Mental Illness					High Blood Pressure				
Arthritis					Kidney Disease				
Asthma					Migraines				
Cancer					Stroke				
Congestive Heart Failure					Sexually Transmitted Disease				
COPD/Emphysema					Seasonal Allergies				
Diabetes					Sleep Apnea				
Gastrointestinal Problems					Substance Abuse				
Gout					Thyroid Disease				
Heart Attack					Other:				

### Female – Please complete

Pregnant?  YES  NO      Planning Pregnancy?  YES  NO      Date of last menstrual cycle: \_\_\_\_\_  
 Menstrual Flow:  Regular  Irregular  Pain/Cramps \_\_\_\_\_ Days of flow  
 Number Of: \_\_\_\_\_ Pregnancies    \_\_\_\_\_ Abortions    \_\_\_\_\_ Miscarriages    \_\_\_\_\_ Live Birth      Birth control method: \_\_\_\_\_

### HOSPITAL ADMISSIONS (Not including pregnancies)

YEAR	ILLNESS OR OPERATION	SURGEON	YEAR	ILLNESS OR OPERATION	SURGEON

DO  
YOU  
NOW  
OR  
HAVE

### YOU EVER CONSUMED:

CIGARETTES                     YES  NO                    PKG. PER DAY \_\_\_\_\_ # OF YEARS \_\_\_\_\_  
 ALCOHOL                       YES  NO                    DRINKS PER WEEK \_\_\_\_\_  
 COFFEE/TEA                   YES  NO                    CUPS/GLASSES PER DAY \_\_\_\_\_  
 DRUGS                           YES  NO

Are you allergic to any medications?  YES  NO

Name of Medication	Type of Reaction	Name of Medication	Type of Reaction
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

### Current Medications (includes Prescriptions, Over the Counter and Herbal)

Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency
1. _____	_____	_____	8. _____	_____	_____
2. _____	_____	_____	9. _____	_____	_____
3. _____	_____	_____	10. _____	_____	_____
4. _____	_____	_____	11. _____	_____	_____
5. _____	_____	_____	12. _____	_____	_____
6. _____	_____	_____	13. _____	_____	_____
7. _____	_____	_____	14. _____	_____	_____

**FAMILY HISTORY:**

	Living	Deceased	Age	Cause of Death
Father				
Mother				
Sibling				
Sibling				
Sibling				

Have any of your blood relatives ever had any of the following conditions? If so, who?

Condition	Yes	No	Relation	Condition	Yes	No	Relation
Anemia/Bleeding Disorder				Gout			
Anxiety/Depression				Heart Disease/Heart Attack			
Other Mental Illness				High Blood Pressure			
Arthritis				Kidney Disease			
Asthma				Migraines			
Cancer				Stroke			
High Cholesterol				Thyroid Disease			
Congestive Heart Failure				Seasonal Allergies			
COPD/Emphysema				Sleep Apnea			
Diabetes				Other			

**Reason for today's visit:** \_\_\_\_\_

Are you currently experiencing any of these symptoms?

Symptom	Yes	No	Symptom	Yes	No	Symptom	Yes	No
<b>GENERAL</b>								
Chills			Sleeping Difficulties			Recent weight loss or gain		
Fever			Fatigue or Exhaustion			Change in appetite		
<b>SKIN</b>								
Change in moles,body,hair,rash			Bleeds easily			Itching or Burning		
<b>HEENT</b>								
Frequent Headaches			Dry eyes			Ear infections		
Neck lumps or swelling			See double			Nose bleeding		
Glaucoma			Eyesight worsening			Sinusitis		
Glasses			Hearing difficulty			Allergies		
See halos around light			Buzzing or roaring in ears			Hoarse voice		
<b>RESPIRATORY</b>								
Wheezes			Coughed up Phlegm			Shortness of breath/painful breathing		
Daily cough			Coughed up blood			Night sweating		
<b>GASTROINTESTINAL</b>								
Difficulty swallowing			Regurgitation of stomach acid			Black, tarry stools		
Food intolerance			Vomited blood			Nausea or vomiting		
Indigestion treatment			Constipation			Change in stool color or size		
Belching			Blood in stools					
<b>GENITOURINARY/GYN</b>								
Get up at night to urinate			Testicles: painful or lumps			Vaginal discharge		
Burning on urination			Discharge			Nipple discharge		
Difficulty starting/stopping urine			Menstrual trouble			Hot flashes		
Frequent urination			Previous Breast biopsy?			Mood changes or irritability		
Brown, black or bloody urine			Lumps in breast			Abnormal pap smears		
<b>CARDIOVASCULAR</b>								
Chest pain			Leg cramps while walking			Leg or Ankle swelling		
Chest tightness/Arm Pain			Skipped heart beats or palpitations			Smothering spells		
<b>MUSCULOSKELETAL</b>								
Arthritis or swollen joints			Back or shoulder problems			Sciatica		
Bursitis or tendonitis			Painful feet			Neck pain		
<b>METABOLIC</b>								
Diabetes or sugar in urine			Thyroid disease			Tend to be hot or cold		
<b>NEURO/PSYCHOLOGICAL</b>								
Fainting or blackouts			Difficulty speaking			Depression or anxiety/Cry or worry a lot		
Numbness			Work or family problems			Significant change in memory		
Tend to tremble or shake			Considered suicide			Decline in mental ability		