

# history and physical



Name: \_\_\_\_\_

Date: \_\_\_\_\_

## social:

Age: \_\_\_\_\_ Sex:  M  F Married:  Yes  No Occupation: \_\_\_\_\_

Responsible adult available to assist during recovery period:  Yes  No Relationship: \_\_\_\_\_

## habits:

Smoke, Amount \_\_\_\_\_  Coffee/Tea/Cola, Amount \_\_\_\_\_

Alcohol, Amount \_\_\_\_\_  Daily Exercise, Amount \_\_\_\_\_

## medications:

### List dose or number of pills per day

Prescription Drugs

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Non Prescription (Vitamins; Herbs)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Regular Aspirin Use, Dosage & frequency \_\_\_\_\_

NSA (Advil, Motrin, Ibuprofen), Dosage & frequency \_\_\_\_\_

Cortisone Injections Past Year, Date(s) and injection location \_\_\_\_\_

Drug Allergy, List drug(s) and type of reaction \_\_\_\_\_

Latex Allergy

Tape Allergy

## family history:

### Have any blood relatives ever had the following problems:

Abnormal Bleeding

Diabetes

Cancer

Tuberculosis

Coronary Surgery

Anesthetic Problems

Hypertension

Other Serious Illness

Abnormal Clotting

Heart Attack

Kidney Disease

Please describe questions with a checkmark \_\_\_\_\_

## women patients only:

Number of pregnancies \_\_\_\_\_ Number of children \_\_\_\_\_ Last menstrual period \_\_\_\_\_  Did you breast feed?

Bra size \_\_\_\_\_ Last MMG \_\_\_\_\_ Results \_\_\_\_\_ Additional breast studies \_\_\_\_\_

## personal past history:

### Have you ever had:

- |   |   |                                       |   |
|---|---|---------------------------------------|---|
| <input type="checkbox"/> Abnormal Bleeding  | <input type="checkbox"/> Angina         | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Snoring                      |
| <input type="checkbox"/> Abnormal Clotting  | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> Weight Change past 12 months |
| <input type="checkbox"/> Acid Regurgitation | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other Serious illness        |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Fainting Spell | <input type="checkbox"/> Sleep Apnea  |   |

Please describe questions with a checkmark \_\_\_\_\_

Have you ever received a transfusion?  Yes  No If yes, what year? \_\_\_\_\_

Have you been tested for HIV?  Yes  No If yes, what year? \_\_\_\_\_ Result:  Positive  Negative

### Do you wear:

- |   |                                      |                                      |                                   |
|---|--------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Contact lenses | <input type="checkbox"/> Eye glasses | <input type="checkbox"/> Hearing aid | <input type="checkbox"/> Dentures |
|---|--------------------------------------|--------------------------------------|-----------------------------------|

Previous Surgery, year and type of procedure \_\_\_\_\_

### Indicate the type(s) of anesthesia received in the past, list any complications / reactions you experienced:

- Local anesthesia - (complications/reactions): \_\_\_\_\_
- General anesthesia - (complications/reactions): \_\_\_\_\_
- Spinal / Epidural - (complications/reactions): \_\_\_\_\_

Date last seen by Primary Care Physician \_\_\_\_\_ Primary Care Physician (name) \_\_\_\_\_

Telephone ( \_\_\_\_\_ ) \_\_\_\_\_ Address \_\_\_\_\_

## review of systems:

- |  |  |   |                                    |
|--|--|---|------------------------------------|
| <input type="checkbox"/> Loose Dental Devices  | <input type="checkbox"/> Vomiting            | <input type="checkbox"/> Recent Upper Respiratory Infection | <input type="checkbox"/> Black Out |
| <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Cough               | <input type="checkbox"/> Current Pregnancy                  | <input type="checkbox"/> Stroke    |
| <input type="checkbox"/> Neck Mobility Problem | <input type="checkbox"/> Difficult Voiding   | <input type="checkbox"/> Normal Menstrual Period            | <input type="checkbox"/> Obesity   |
| <input type="checkbox"/> Irregular Heart Beat  | <input type="checkbox"/> Shortness of Breath |   |                                    |
| <input type="checkbox"/> Short Neck            | <input type="checkbox"/> Seizure             |   |                                    |

### Additional Form Comments:

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Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_