

History & Physical

Name _____ SS# _____ Date _____
Clinic # _____ Hospital # _____
Address _____ Occupation _____
Phone (home) _____ (work) _____ DOB _____ Age _____

Chief Complaint

History of Present Illness

Current Medications

changes date

_____	_____
_____	_____
_____	_____
_____	_____

Medical History

Headache/Migraine _____
Headache/Tension _____
Epilepsy/Seizures _____
Cerebro vascular _____
Other neuromuscular _____
Head injury _____
Spinal cord injury _____
Cervical spine disease _____
Lumbar spine disease _____
Peripheral nerve _____
CNS malignancy _____
Depression _____
Coronary artery disease _____
MI _____
Arrhythmias _____
Congestive heart failure _____

Murmur _____
Hypertension _____
COPD _____
Pneumonia _____
Asthma _____
Peptic ulcer disease _____
Colonic polyps _____
Bleeding disorder _____
Anemia _____
Diabetes _____
Peripheral vascular disease _____
Thyroid disease _____
Menstrual/Sexual dysfunction _____
Other Endocrine _____
Liver disease/Hepatitis _____
Renal disease _____

Genitourinary disease _____
Venereal disease _____
Arthritis _____
Cancer _____
Tuberculosis _____
HIV _____
E+OH abuse _____
Smoking _____
Drug use _____
Exposures _____
Mumps _____
Measles _____
Polio _____
Rheumatic fever _____
Allergy/hay fever _____
Other _____

Drug Allergies

