Patient History & Physical Form

Patient _____ Age _____ Birthdate _____
(Last) (First) (Middle)

Current Medications _____

Drug Allergies _____

Check if you (describe usage): [ ] Smoke [ ] Drink [ ] Use Marijuana / Other Drugs _____

Surgeries, Illness, And /Or Injuries _____

_____

Menstrual Periods: Last Period Date Was _____. Period comes every _____ days and flow lasts _____ days.

Period began at age _____. Periods are [ ] Regular or [ ] Irregular Problems: _____ [ ] Gardasil

BIRTH CONTROL: _____ DATE OF LAST PAP SMEAR _____ LAST MAMMOGRAM _____

LIST ALL PREVIOUS PREGNANCIES AND BIRTHS (PLEASE INCLUDE ANY MISCARRIAGES AND/OR ABORTIONS)

Infant Birthdate	Sex:	Infant Birth Weight:	Length of Pregnancy	Length of Labor	Complications

CHECK IF YOU HAVE A PERSONAL HISTORY OF ANY OF THE FOLLOWING:

- [ ] Abnormal mammogram
- [ ] Abnormal pap smear
- [ ] Abnormal vaginal bleeding
- [ ] Abuse- Sexual / Physical
- [ ] Acne
- [ ] Alcoholism
- [ ] Allergies
- [ ] Arthritis
- [ ] Asthma
- [ ] Anemia
- [ ] Blood Clots
- [ ] Blood Transfusion
- [ ] Breast Disease
- [ ] Cancer
- [ ] Cholesterol elevation
- [ ] Constipation
- [ ] Depression
- [ ] Diabetes / low blood sugar
- [ ] Diarrhea
- [ ] Diverticulosis
- [ ] Drug Dependency
- [ ] Emotional problems
- [ ] Endometriosis
- [ ] Epilepsy / seizures
- [ ] Eye problems
- [ ] Fainting
- [ ] Gallbladder problems
- [ ] Headaches
- [ ] Heart problems
- [ ] Hemorrhoids
- [ ] Hepatitis
- [ ] Hernia
- [ ] High blood pressure
- [ ] HIV testing
- [ ] Intestinal problems
- [ ] Kidney disease
- [ ] Liver disease
- [ ] Menstrual period pain
- [ ] Neurologic problems
- [ ] Ovarian tubal infections
- [ ] Pain with intercourse
- [ ] Pelvic / abdominal pain
- [ ] Pelvic inflammatory disease
- [ ] Respiratory problems
- [ ] Rheumatic / scarlet fever
- [ ] Sexual problems
- [ ] Stroke
- [ ] Sickle cell anemia
- [ ] Thrombophlebitis
- [ ] Thyroid disease
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Urinary tract infections.
- [ ] Urinary incontinence
- [ ] Varicose veins
- [ ] Vaginal discharge
- [ ] Vaginal infections
  - [ ] Chlamydia [ ] Trichomonas
  - [ ] Gonorrhea [ ] Warts
  - [ ] Herpes [ ] Yeast
  - [ ] Syphilis [ ] Other
- [ ] Vomiting
- [ ] Other

CHECK IF YOU HAVE A FAMILY HISTORY OF ANY OF THE FOLLOWING

- [ ] Alcoholism
- [ ] Cancer _____
- [ ] Congenital problems _____
- [ ] Adopted
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Heart disease
- [ ] High blood pressure
- [ ] Kidney disease
- [ ] Lung disease
- [ ] Mental illness
- [ ] Other _____

PROVIDER NOTES: