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H & P

DATE_____

I. Basic Data

Name_____ Age_____ Sex_____ (Circle One) S W M D

Date of Birth _____

Briefly describe the duties of your occupation_____

II. State in your own words your reason(s) for seeing the doctor_____

_____

_____

_____

III. History of prior surgeries

A. **OPERATION** **DATE** **HOSPITAL**

_____

_____

_____

_____

B. Recent severe illnesses or injuries

ILLNESS **DATE** **HOSPITAL**

_____

_____

_____

C. Other medical history

ILLNESS **DATE** **TOWN** **DOCTOR**

_____

_____

_____

IV. List medications you are now taking (dosage - size of tablet - how often)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

V. Allergies: medications, foods, latex

Medicine | Type of Reaction

_____

_____

_____

Y N	Allergy to Foods	
Y N	Allergy to Latex	

A. Date of your last complete physical examination? _____

Doctor _____

B. Last pap smear _____

C. Last rectal exam _____ D. Last breast exam _____

E. Immunizations last given M / D / YY

Tetanus Toxoid		Hepatitis B (Active)	
Flu Vaccine		Hepatitis B Shot #2	
Pneumonia Vaccine		Hepatitis B Shot #3	
Hepatitis A		Vaccines (Others)	
Hepatitis A #2			

VI. Family History

Diagnosis	Family Hx	Father	Mother	Brother	Sister	PG-Father	PG-Mother	MG-Father	MG-Mother
Cancer	Y N								
Breast Cancer	Y N								
Prostate Cancer	Y N								
Heart Attack	Y N								
Heart Disease	Y N								
Stroke	Y N								
Hypertension	Y N								
Diabetes	Y N								
Thyroid Disorders	Y N								
Kidney Disease	Y N								
Neurologic Disorders	Y N								
Pulmonary Disease	Y N								
Liver Diseases	Y N								
Mental Illness	Y N								
Gout	Y N								
Deceased	Y N								
Age of Deceased									

Children's Medical History / Serious Illnesses

Endocrine Symptoms	
Temperature Intolerance to Heat (Consistent)	Y N
Temperature Intolerance to Cold (Consistent)	Y N
Temperature Intolerance Alternately Too Hot and Too Cold	Y N Y N
Excessive Sweating	Y N
Excessive Thirst	Y N
Reported Tests" Urine was Positive for Sugar	Y N
Changed Sexual Interest (Libido)	Y N
Sexual Ability the Same	Y N

Weight	
Recent Weight Loss (_____lbs) [Reported] (lbs)	Y N
Recent Weight Gain (_____lbs) [Reported] (lbs)	Y N
Currently on a Diet	Y N

Musculoskeletal Symptoms	
Diffuse Joint Pains (Arthralgias)	Y N
Joint Swelling	Y N
Sx: Skin Lump	Y N
Arthritis	Y N
Reported Prior Back Trouble	Y N
Reported Prior Neck Trouble	Y N
Reported a Previous Medical History of Fracture	Y N

Vascular Symptoms	
Leg Pain with Exercise (Leg Claudication)	Y N
Pain Worse with Weight-bearing	Y N
Swelling of the Arms or Hands	Y N
Swelling of the Legs or Feet	Y N
History of Hemorrhoids	Y N
History of Varicose Veins	Y N

Skin Symptoms	
Reported Prior Skin Problems	Y N

Social History	
Amount of Sleep (hours/day)	
Daily coffee Consumption (cups per day)	
Alcohol Use, Past or Present (Drinks Per Week) _____	Y N
Smoking, Past (Packs per Day / Years) _____/_____ Present (Packs per Day / Years) _____/_____	Y N Y N
Cultural Background (example: German) _____	
Language _____	
Race (example: White, Black, Hispanic)_____	

Neuropsychiatric	
Neurological Symptoms	
Paralysis	Y N
Reported Head Trauma with Brief Unconsciousness	Y N
History of Convulsions	Y N
Any Numbness (Hypoesthesia)	Y N
Psychological Symptoms	
Feeling Nervous	Y N
Anxiety with a Persistent Worry	Y N
Depression	Y N
Anxiety with Muscle Tension	Y N

Obstetrics and Gynecology	
Pregnancy History	Y N
Previous Miscarriage(s) _____	Y N
Pregnant with Complications	Y N
History of Pregnancy-Induced Hypertension	Y N
History of Reported Tests: Urine was Positive for Protein	Y N
Date of Last Menstrual Period _____	
Menses Abnormal	Y N
Menses Duration _____ days	
Hot Flashes	Y N
Menopause Has Occurred	Y N
Regular Cycle Intervals	Y N
Bleeding Between Periods	Y N

Name _____ D.O.B _____

Review of Systems			
Rheumatic	Y N	Urticaria (Hives)	Y N
Scarlet Fever	Y N	Diabetes	Y N
Heart Disease	Y N	Kidney Disease	Y N
Hypertension (Systemic)	Y N	Liver disease	Y N
Pneumonia	Y N	Jaundice	Y N
Pleurisy	Y N	Gallbladder Disease	Y N
Tuberculosis	Y N	Anemia	Y N
Asthma	Y N	Cancer	Y N
Hay Fever	Y N	Blood Transfusion	Y N
HIV	Y N	Hepitis	Y N

Head-Related Symptoms	
Headache	Y N
Dizziness	Y N
Fainting (Syncope)	Y N

Eye Symptoms	
Eyesight Problems	Y N
Currently Wearing Eyeglasses	Y N
White/Light Spots in Field of Vision	Y N
Seeing Double Images (Diplopia)	Y N
Eye Pain	Y N
Seeing Periodic Flashing Lights (Photopsia)	Y N

ENT Symptoms	
Ear Symptoms	
Loss of Hearing	Y N
Spinning Dizziness (Vertigo)	Y N
Ringing in the Ears (Tinnitus)	Y N
Nasal Symptoms	
Sinusitis	Y N
Throat Symptoms	
Hoarseness	Y N
Difficulty Swallowing with Food Sticking	Y N

Cardiorespiratory	
Cardiovascular Symptoms	
Tiring Easily	Y N
Chest Pain or Discomfort	Y N
Palpitations Which Are Pounding	Y N
Reported a Previous Heart Murmur	Y N
Reported Previous High Blood Pressure	Y N
Pulmonary Symptoms	
Shortness of Breath	Y N
Difficult Breathing Worsens with Lying Down	Y N
Awakening at Night Short of Breath	Y N
Cough	Y N
Chest Pain Starts When in a Cold Environment	Y N
Coughing Up Blood (Hemoptysis)	Y N
Coughing Up Thick Yellow-Green Sputum (Purulent)	Y N
Asthma	Y N
Emphysema	Y N

Gastrointestinal	
Decrease in Appetite	Y N
Nausea	Y N
Vomiting	Y N
Abdominal Pain	Y N
Diarrhea	Y N
Constipation	Y N
Vomiting Blood (Hematemesis)	Y N
Red Blood in Bowel Movement (Hematochezia)	Y N
Bowel Movement Frequency Recent Change	Y N
Black or Tarry Stools (Melena)	Y N
Gastric Ulcer	Y N
Peptic Ulcer	Y N
Acute Ulcer	Y N

Genitourinary Symptoms	
Reported Tests: Urine was Positive for Protein	Y N
Urinary Tract Infection	Y N
Urinary Frequency More than Twice at Night (Nocturia)	Y N
Urinary Stream is Smaller	Y N
Urinary Loss of Control	Y N
Blood in the Urine	Y N
Bladder Calculus	Y N
Infection of Kidney	Y N
Cystitis	Y N