

PATIENT HISTORY AND PHYSICAL

Name _____ Date _____

Reason for today's office visit: _____

List any current medications taken on a regular basis: _____

List previous hospitalizations/surgeries: _____

Pre-Existing Conditions

	<u>Patient</u>	<u>Family</u>		<u>Patient</u>	<u>Family</u>
<u>Eyes, Ears</u>					
<u>Nose, Throat</u>			<u>Musculoskeletal</u>		
Glaucoma	_____	_____	Neck	_____	_____
Cataracts	_____	_____	Back	_____	_____
Thyroid	_____	_____	Joints	_____	_____
<u>Heart</u>			<u>Skin</u>		
Hypertension	_____	_____	Eczema	_____	_____
<u>Lungs</u>			<u>Neurological</u>		
Asthma	_____	_____	Epilepsy	_____	_____
Emphysema	_____	_____	Migraines	_____	_____
Tuberculosis	_____	_____	<u>Psychiatric</u>		
<u>Gastrointestinal</u>			Depression	_____	_____
Ulcers	_____	_____	<u>Endocrine</u>		
Crohns	_____	_____	Diabetes	_____	_____
Hernia	_____	_____	<u>Blood</u>		
Hepatitis	_____	_____	Lymphoma	_____	_____
<u>Genitourinary</u>			<u>Allergy</u>		
Bladder	_____	_____	Food	_____	_____
<u>Cancer</u>			Medicine	_____	_____