Ivy Falls Family Medicine

HISTORY AND PHYSICAL

Date: ____/____/_____

Name: _____ Date of Birth: _____/_____/_____

DRUG ALLERGIES

_____
_____
_____
_____
_____

CURRENT MEDICATIONS

_____
_____
_____
_____
_____

FAMILY HISTORY

	Father	Mother	Siblings	Children	Paternal/Maternal Grandparents	
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Deceased	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

Reason Date

_____
_____
_____
_____

MEDICAL HISTORY

☐Headache ☐Shortness of Breath ☐Heart Palpitations ☐Heart Murmur ☐Chest Pain
☐Dizziness ☐Peripheral vascular disease ☐Allergies ☐Asthma ☐Bronchitis
☐Pneumonia ☐Ulcer ☐GI Disorder ☐Lactose Intolerance ☐Gallbladder Disease ☐Prostate Disease
☐Bowel Irregularity ☐Incontinence ☐Sexual/Menstrual dysfunction ☐Venereal Disease
☐Frequent Infections ☐Hepatitis ☐Anemia ☐Arthritis ☐Osteoporosis ☐Nervousness
☐Depression ☐Gout ☐Chronic Rash ☐Mumps ☐Measles ☐Rubella ☐Polio
☐Diphtheria ☐Tetanus ☐_____ ☐_____

HABITS

☐Smoke: packs daily _____ how long _____ would you like information about quitting? _____
☐Coffee: cups daily _____ other caffeine (tea, soda) _____☐Alcohol: type/amount _____
☐Diet: salt intake _____ ☐Exercise routine_____ ☐Other _____
☐Sleep: difficulty falling asleep _____ continuity disturbances _____ snoring _____
Early morning awakening _____ daytime drowsiness _____
☐Contact with blood or body fluid at work _____

Signature:_____