Physical

Name:		Date:
Chief Complaint:	**Birth Date:**	**Age:**
Drug Allergies:		

Medication List

Medication:	Strength:	Dosing:

Immunizations and most recent date:

- ☐ Hepatitis A:_____ ☐ Hepatitis B:_____
- ☐ Influenza (Flu):_____ ☐ HPV:_____
- ☐ Tdap (Tetanus, Diphtheria, Pertussis):_____
- ☐ MMR (Measles, Mumps, Rubella):_____
- ☐ Meningococcal:_____ ☐ Pneumococcal:_____
- ☐ Varicella (Chickenpox):_____
- ☐ Zoster (Shingles):_____

Medical History:

☐ Abdominal Pain	☐ Eye Infections	☐ Moodiness	☐ Stroke
☐ Allergies/Hayfever	☐ Chronic Fatigue	☐ Mumps	☐ Difficulty Swallowing
☐ Anemia ☐ Bruise Easily	☐ Foot Pain	☐ Muscle Weakness	☐ Tentanus
☐ Swollen Ankles	☐ Cold Numb Feet	☐ Nausea/Vomiting	☐ Sore Throat
☐ Arthritis/Rheumatism	☐ Gall Bladder Trouble	☐ Nervousness	☐ Thyroid Disease
☐ Asthma/Wheezing	☐ Gout	☐ Nose Bleeds	☐ Tremor/Shaking Hands
☐ Back Pain	☐ Hair Loss	☐ Numbness/Tingling	☐ Tuberculosis
☐ Bone Fracture/Joint Injury	☐ Headaches	☐ Osteoporosis	☐ Peptic Ulcers
☐ Bronchitis/Chronic Cough	☐ Heart Murmur	☐ Phobias	☐ Urethral Discharge
☐ Cancer	☐ Hemorrhoids	☐ Pneumonia	☐ Frequent Urination
☐ Chest Pain	☐ Hernia	☐ Polio	☐ Painful Urination
☐ Chicken Pox	☐ High Blood Pressure	☐ Prostate Disease	☐ Incontinence
☐ Convulsions/Seizures	☐ Indigestion/Heartburn	☐ Psoriasis ☐ Eczema	☐ Blood in Urine
☐ Depression/Anxiety	☐ Frequent Infections	☐ Rashes ☐ Hives	☐ Varicose Veins/Phlebitis
☐ Diabetes	☐ Jaundice/Hepatitis	☐ Rheumatic Fever	☐ Venereal Disease
☐ Diphtheria	☐ Kidney Stones	☐ Rubella	☐ Failing Vision
☐ Diverticulosis/Colitis	☐ Leg Pain	☐ Scarlet Fever	☐ Recent Weight Loss
☐ Dizziness/Fainting	☐ Measles	☐ Sexual Dysfunction	☐ Recent Weight Gain
☐ Ear Infections	☐ Memory Loss	☐ Pain During Sex	☐ Other:_____
☐ Ringing in Ears	☐ Mental Illness	☐ Sinus Trouble	☐ Other:_____

List past surgeries and hospitalizations:

Incident:	Date:	Reason:	Comments:

Family History:

	Father	Mother	Child	Sibling	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐

Please rate the following:

Energy Levels ☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None

Stress Levels ☐ Very High ☐ High ☐ Moderate ☐ Low ☐ None

Do/did you smoke? ☐ Yes ☐ No

years:_____ # packs per day:_____

year quit:_____

Are you on a special diet?

☐ Vegan ☐ Vegetarian (ovo-lacto) ☐ Pescetarian (seafood)

☐ Gluten Free ☐ Low Carb/Paleo ☐ Diabetic/Sugar Free

☐ Other:_____

Rate how often you:

Eat Fast Foods ☐ Low ☐ Medium ☐ High #meals/week:_____

Dine Out ☐ Low ☐ Medium ☐ High #meals/week:_____

Cook Fresh ☐ Low ☐ Medium ☐ High #meals/week:_____

Do you ever experience gas?

☐ Often ☐ Occasionally ☐ Rarely

How often to you typically have a bowel movement?

☐ More than 3 times a day ☐ 1-3 times a day

☐ 4-6 times a week ☐ 2-3 times a week ☐ 1 or less times a week

How would you describe your bowel movements?

☐ Soft and well formed ☐ Often floats ☐ Difficult to pass

☐ Diarrhea ☐ Thin, long and narrow ☐ Small and hard

☐ Loose but not watery ☐ Alternating loose/hard

☐ Greasy or shiny ☐ Brown ☐ Yellow or light brown

☐ Color Varies ☐ Dark or black ☐ Greenish

What kind of exercises do you do?

☐ Jogging/Walking ☐ Weight Training ☐ Golf

☐ Cardio Machines ☐ Aerobics ☐ Pilates ☐ Tennis

☐ Yoga ☐ Organized Sports

☐ Other:_____

Rate your intake:

Fruit ☐ Low ☐ Medium ☐ High #servings/day:_____

Vegetables ☐ Low ☐ Medium ☐ High #servings/day:_____

Protein ☐ Low ☐ Medium ☐ High #servings/day:_____

Type of protein: ☐ red meat ☐ poultry ☐ fish ☐ dairy ☐ beans/soy ☐ other:_____

Fiber ☐ Low ☐ Medium ☐ High #servings/day:_____

Salt ☐ Low ☐ Medium ☐ High #servings/day:_____

Fat ☐ Low ☐ Medium ☐ High #servings/day:_____

Sugar ☐ Low ☐ Medium ☐ High #servings/day:_____

Processed Food ☐ Low ☐ Medium ☐ High #servings/day:_____

Water ☐ Low ☐ Medium ☐ High #servings/day:_____

Caffeine ☐ Low ☐ Medium ☐ High #servings/day:_____

Alcohol ☐ Low ☐ Medium ☐ High #servings/week:_____

Type of alcohol: ☐ wine ☐ beer ☐ liquor ☐ mixed

How many times a week do you exercise?

How many hours do you sleep a night?

Do you wake feeling rested?

☐ Yes ☐ No

Do you experience:

☐ Difficulty falling asleep ☐ Waking in the night ☐ Daytime drowsiness

Women Only

Menstrual Flow:

☐ Regular ☐ Irregular ☐ Pain/Cramps

# of days:_____ last period:_____

Pregnancy:

Are you: ☐ Pregnant ☐ Trying/Planning to get pregnant

# of pregnancies:_____ abortions:_____ miscarriages:_____ live births:_____

Method of birth control:

Last OB/GYN exam:

Date:_____

☐ Normal ☐ Abnormal

Last mammogram:

Date:_____

☐ Normal ☐ Abnormal