

Physical

Name:		Date:	
Chief Complaint:		Birth Date:	Age:
Drug Allergies:			
Medication List		Immunizations and most recent date:	
Medication:	Strength:	Dosing:	<input type="checkbox"/> Hepatitis A: _____ <input type="checkbox"/> Hepatitis B: _____ <input type="checkbox"/> Influenza (Flu): _____ <input type="checkbox"/> HPV: _____ <input type="checkbox"/> Tdap (Tetanus, Diphtheria, Pertussis): _____ <input type="checkbox"/> MMR (Measles, Mumps, Rubella): _____ <input type="checkbox"/> Meningococcal: _____ <input type="checkbox"/> Pneumococcal: _____ <input type="checkbox"/> Varicella (Chickenpox): _____ <input type="checkbox"/> COVID-19: _____ <input type="checkbox"/> Zoster (Shingles): _____ <input type="checkbox"/> Other: _____
Medical History:			
<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Allergies/Hayfever <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Swollen Ankles <input type="checkbox"/> Arthritis/Rheumatism <input type="checkbox"/> Asthma/Wheezing <input type="checkbox"/> Back Pain <input type="checkbox"/> Bone Fracture/Joint Injury <input type="checkbox"/> Bronchitis/Chronic Cough <input type="checkbox"/> Cancer <input type="checkbox"/> Chest Pain <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Convulsions/Seizures <input type="checkbox"/> COVID-19 <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Diabetes <input type="checkbox"/> Diphtheria <input type="checkbox"/> Diverticulosis/Colitis <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Ear Infections	<input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Eye Infections <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Foot Pain <input type="checkbox"/> Cold Numb Feet <input type="checkbox"/> Gall Bladder Trouble <input type="checkbox"/> Gout <input type="checkbox"/> Hair Loss <input type="checkbox"/> Headaches <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hernia <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Indigestion/Heartburn <input type="checkbox"/> Frequent Infections <input type="checkbox"/> Jaundice/Hepatitis <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Leg Pain <input type="checkbox"/> Measles <input type="checkbox"/> Memory Loss	<input type="checkbox"/> Mental Illness <input type="checkbox"/> Moodiness <input type="checkbox"/> Mumps <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Nervousness <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Phobias <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate Disease <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema <input type="checkbox"/> Rashes <input type="checkbox"/> Hives <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rubella <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Pain During Sex	<input type="checkbox"/> Sinus Trouble <input type="checkbox"/> Stroke <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Tetanus <input type="checkbox"/> Sore Throat <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tremor/Shaking Hands <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Peptic Ulcers <input type="checkbox"/> Urethral Discharge <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Incontinence <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Varicose Veins/Phlebitis <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Failing Vision <input type="checkbox"/> Recent Weight Loss <input type="checkbox"/> Recent Weight Gain <input type="checkbox"/> Other: _____
List past surgeries and hospitalizations:			
Incident:	Date:	Reason:	Comments:

Family History:	Father's Mother's						Father's Mother's						
	Father	Mother	Child	Sibling	Parents	Parents	Father	Mother	Child	Sibling	Parents	Parents	
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please rate the following:							Do/did you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Energy Levels <input type="checkbox"/> Very High <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> None							# years:_____ # packs per day:_____						
Stress Levels <input type="checkbox"/> Very High <input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input type="checkbox"/> None							year quit:_____						
Are you on a special diet?							Rate how often you:						
<input type="checkbox"/> Vegan <input type="checkbox"/> Vegetarian (ovo-lacto) <input type="checkbox"/> Pescetarian (seafood)							Eat Fast Foods <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #meals/week:_____						
<input type="checkbox"/> Gluten Free <input type="checkbox"/> Low Carb/Paleo <input type="checkbox"/> Diabetic/Sugar Free							Dine Out <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #meals/week:_____						
<input type="checkbox"/> Other:_____							Cook Fresh <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #meals/week:_____						
Do you ever experience gas?							Rate your intake:						
<input type="checkbox"/> Often <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely							Fruit <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/day:_____						
How often to you typically have a bowel movement?							Vegetables <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/day:_____						
<input type="checkbox"/> More than 3 times a day <input type="checkbox"/> 1-3 times a day							Protein <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/day:_____						
<input type="checkbox"/> 4-6 times a week <input type="checkbox"/> 2-3 times a week <input type="checkbox"/> 1 or less times a week							Type of protein: <input type="checkbox"/> red meat <input type="checkbox"/> poultry <input type="checkbox"/> fish						
How would you describe your bowel movements?							<input type="checkbox"/> dairy <input type="checkbox"/> beans/soy <input type="checkbox"/> other:_____						
<input type="checkbox"/> Soft and well formed <input type="checkbox"/> Often floats <input type="checkbox"/> Difficult to pass							Fiber <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/day:_____						
<input type="checkbox"/> Diarrhea <input type="checkbox"/> Thin, long and narrow <input type="checkbox"/> Small and hard							Salt <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/day:_____						
<input type="checkbox"/> Loose but not watery <input type="checkbox"/> Alternating loose/hard							Fat <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/day:_____						
<input type="checkbox"/> Greasy or shiny <input type="checkbox"/> Brown <input type="checkbox"/> Yellow or light brown							Sugar <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/day:_____						
<input type="checkbox"/> Color Varies <input type="checkbox"/> Dark or black <input type="checkbox"/> Greenish							Processed Food <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/day:_____						
What kind of exercises do you do?							Water <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/day:_____						
<input type="checkbox"/> Jogging <input type="checkbox"/> Walking <input type="checkbox"/> Weight Training <input type="checkbox"/> Golf							Caffeine <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/day:_____						
<input type="checkbox"/> Cardio Machines <input type="checkbox"/> Aerobics <input type="checkbox"/> Pilates <input type="checkbox"/> Tennis							Alcohol <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High #servings/week:_____						
<input type="checkbox"/> Yoga <input type="checkbox"/> Organized Sports							Type of alcohol: <input type="checkbox"/> wine <input type="checkbox"/> beer <input type="checkbox"/> liquor <input type="checkbox"/> mixed						
<input type="checkbox"/> Other:_____													
How many times a week do you exercise?				How many hours do you sleep a night?				Do you wake feeling rested?					
								<input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you experience:													
<input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Waking in the night <input type="checkbox"/> Daytime drowsiness													
Women Only													
Menstrual Flow:						Pregnancy:							
<input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps						Are you: <input type="checkbox"/> Pregnant <input type="checkbox"/> Trying/Planning to get pregnant							
# of days:_____ last period:_____						# of pregnancies:_____ abortions:_____ miscarriages:_____ live births:_____							
Method of birth control:						Last OB/GYN exam:				Last mammogram:			
						Date:_____				Date:_____			
						<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal				<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			