HISTORY AND PHYSICAL

Name _____ S.S.# _____ Date _____

Phone (Home) _____ (Work) _____ Birth Date _____

DRUG ALLERGIES

CURRENT MEDS

HOSPITALIZATION OR SURGERY

FAMILY HISTORY

	YOURSELF	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐
Colon CA/Polyps	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐	☐
Ulcer	☐	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐	☐
Alcoholism	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐
COPD/Asthma	☐	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐	☐

PAST MEDICAL HISTORY

- ☐ Headaches _____
- ☐ Shortness of breath _____
- ☐ Heart palpitations _____
- ☐ Heart murmur _____
- ☐ Arrythmias _____
- ☐ M.I.'s _____
- ☐ CHF _____
- ☐ High cholesterol _____
- ☐ Chest pain _____
- ☐ Dizziness/Fainting _____
- ☐ Peripheral vascular disease _____
- ☐ Allergies/Hay fever _____
- ☐ Endocrine disease _____
- ☐ Bronchitis _____
- ☐ Pneumonia _____
- ☐ Lactose intolerance _____
- ☐ Gall bladder Disease _____
- ☐ Prostate disease _____
- ☐ Bowel irregularity _____
- ☐ Bladder/Urinary problems _____
- ☐ Sexual/Menstrual dysfunction _____
- ☐ Sexually transmitted disease _____
- ☐ Frequent infections _____
- ☐ Hepatitis _____
- ☐ Anemia _____
- ☐ Back/Joint pain _____
- ☐ Osteoporosis _____
- ☐ Nervousness _____
- ☐ Anxiety/Fatigue _____
- ☐ GI disorder _____
- ☐ Depression _____
- ☐ Gout _____
- ☐ Scarlet fever _____
- ☐ Chronic rashes _____
- ☐ Rheumatic fever _____
- ☐ Mumps _____
- ☐ Measles _____
- ☐ Rubella _____
- ☐ Polio _____
- ☐ Diphtheria _____
- ☐ Tetanus _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

WOMEN ONLY

Pregnant? ☐ Yes ☐ No Planning Pregnancy? ☐ Yes ☐ No Complications? ☐ Yes ☐ No

HABITS

- ☐ Smoke: Packs Daily _____ How Long _____ When Stopped _____
- ☐ Exercise Routine _____ ☐ Coffee: Daily Cups _____ Other Caffeines _____
- ☐ Alcohol: Type/Amount _____ ☐ Sleep Pattern _____ ☐ Diet: Salt _____

Ocean Pulmonary Associates, P.A.