Clear Form

LOURDES

Patient
History and Physical

Site:

Print Form

If you have not already done so, please complete this form and return it to our office at the time of your appointment.

Name:_____ Date:_____

Address:_____ DOB:_____

_____ Age:_____

Past Medical History: (Tonsillectomy, Appendectomy, etc.)

	Surgery	Date	Surgeon	Hospital
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Hospitalization(s), Injuries, and Major Illnesses: (List all dates, hospitals, etc.)

1._____

2._____

3._____

4._____

Medication(s): (Only current medications, dose and directions)

1._____ 2._____ 3._____

4._____ 5._____ 6._____

7._____ 8._____ 9._____

Social History: (List any past or present use of the following, give approximate daily amount used)

Tobacco products – cigars, pipes, cigarettes:_____

Coffee, tea, caffeinated soft drinks:_____

Recreational drugs or alcohol:_____

Family History: (Living or deceased, age, major illnesses or cause of death)

Father:_____ Mother: _____

Brothers/Sisters:_____ Children:_____

_____ _____

Psychosocial History: (List information as applicable)

Language barriers:_____

Cultural differences:_____

Domestic violence/Sexual assault/Abuse:_____

Learning barriers:_____

Date of last Tetanus Booster (If known):_____

Re-Order # Net 068 3/30/11 PB001, 2h, 2 side

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Please use care and accuracy in answering the following questions:

Have you ever been told, received treatment, or advice from any physician, practitioner, or health facility that you have:	Yes	No
1. Disease of the heart, veins, arteries, chest pain?	☐	☐
2. High blood pressure (hypertension)?	☐	☐
3. Heart murmur, rheumatic fever?	☐	☐
4. Electrocardiogram in the last 5 years? If so, when & why:_____	☐	☐
5. Tuberculosis, Asthma, Bronchitis?	☐	☐
6. Pneumonia, Emphysema?	☐	☐
7. Chronic cough or spitting blood?	☐	☐
8. Cancer, tumor?	☐	☐
9. Diabetes, sugar, albumin, blood in urine?	☐	☐
10. Thyroid disease?	☐	☐
11. Frequent or severe headaches, fainting, blackouts?	☐	☐
12. Epilepsy, stroke?	☐	☐
13. Kidney stones, bloody or painful urination?	☐	☐
14. **Males:** Any prostate disease?	☐	☐
15. **Females:** Breast disease, difficult pregnancies?	☐	☐
16. **Pap smear:** Ever have an abnormal Pap? When was your last pap smear?_____ Provider's name that did the pap smear?_____	☐	☐
17. **Mammogram:** Ever have an abnormal mammogram? When was your last mammogram?_____ Where was it performed?_____	☐	☐
18. Venereal disease, disease of genitalia?	☐	☐
19. Arthritis, "trick" or locked knee, foot or arch?	☐	☐
20. Back or neck trouble, herniated disc?	☐	☐
21. Skin disorders, rash?	☐	☐
22. Eye trouble, eye surgery?	☐	☐
Do your wear corrective lenses?	☐	☐
23. Difficulty hearing?	☐	☐
Do you wear hearing appliance?	☐	☐
24. Chronic ear, eye, nose or throat disease?	☐	☐
25. Bleeding disorder, leukemia, anemia?	☐	☐
26. Disease of lymph glands?	☐	☐
27. Colitis, intestinal problem, bloody or black stool, chronic diarrhea or constipation?	☐	☐
28. Abdominal/stomach pain, gall bladder problems, yellow jaundice, indigestion, polyps or ulcers?	☐	☐
30. Nervous breakdown, convulsions, mental or nervous disorder, memory loss?	☐	☐
31. Treatment for drug addition, alcoholism?	☐	☐

Please be sure to fill out the reverse side of this form.