Physical Form

PATIENT INFORMATION

Today's Date

Patient's Full Name

Patient's Date of Birth

TODAY'S VISIT

What is the reason for your visit?

PAST MEDICAL HISTORY

List any current/ongoing medical problems or conditions

Previous medical problems, conditions, injuries, illnesses, hospitalizations

Surgeries (and date)

Do you have any allergies? (choose one)

☐ Yes ☐ No

If yes, please list allergies

Medications: list all prescriptions, over-the-counter medications, vitamins, supplements

First Day of Last Period*

**If applicable*

PERSONAL HABITS

What is your occupation?

Do you smoke or vape nicotine? (choose one)

☐ Yes ☐ No

If yes, how much?

Do you drink alcohol? (choose one)

☐ Yes ☐ No

If yes, how much?

Do you use marijuana? (choose one)

☐ Yes ☐ No

If yes, how much?

Do you use recreational drugs? (choose one)

- [ ] Yes
- [ ] No

If yes, what kind and how often?

Do you consider yourself (choose one)

- [ ] Heterosexual
- [ ] Homosexual
- [ ] Bisexual
- [ ] Transgender
- [ ] Queer
- [ ] Something else

Are you in a sexual relationship? (choose one)

- [ ] Yes
- [ ] No

If yes, are your partners (choose one)
if applicable

- [ ] Men
- [ ] Women
- [ ] Both

How do you prevent sexually-transmitted infections?
if applicable

How do you prevent pregnancy?
if applicable

FAMILY MEDICAL HISTORY

Indicate any medical problems in your family
Blood relatives: mother father, sister, brother, grandmother, grandfather, aunt, uncle

- [ ] Anxiety
- [ ] Depression
- [ ] Cancer
- [ ] Diabetes
- [ ] Heart problems
- [ ] High blood pressure
- [ ] Rheumatoid arthritis
- [ ] Colon polyps
- [ ] Early death
- [ ] Mental illness
- [ ] Stroke
- [ ] Suicide
- [ ] Thyroid Disorders
- [ ] Other

If other, please list

- [ ] Unknown family medical history due to adoption or other circumstances

HEALTH MAINTENANCE

Date of last mammogram
**If applicable*

Date of last Pap test
**If applicable*

Have you ever had an abnormal Pap test? (choose one)
**if applicable*

- [ ] Yes
- [ ] No

If yes, any treatment for abnormal Pap (choose one)

- [ ] Biopsy
- [ ] Cryotherapy
- [ ] Laser
- [ ] Surgery

Date of last Colonoscopy
**If applicable*

Have you had a cardiac stress test? (choose one)

- [ ] Yes
- [ ] No

If yes, what was the date?

Have you had a chest x-ray? (choose one)

- [ ] Yes
- [ ] No

If yes, what was the date?

Do you perform self-breast exam? (choose one)
**If applicable*

☐ Yes ☐ No

Do you perform self-testicular exams? (choose one)
**If applicable*

☐ Yes ☐ No

When was your last dental visit?

When was your last eye exam?

When was your last hearing exam?
