HISTORY AND PHYSICAL

Name		**Date**			
REASON FOR YOUR VISIT TODAY:_____					
Allergies		**DOB**		**Age**	
	Last Physical Exam?_____ Labs?_____		**PCP Name/Ph #_____** **Referred by_____**		

MEDICATIONS	**YOUR MEDICAL PROBLEMS**	**VITAMINS/SUPPLEMENTS/HERBALS**

FAMILY MEDICAL HISTORY (Circle)

☐High blood pressure ☐Heart trouble ☐Stroke ☐Anemia ☐Allergies ☐Migraines ☐Bleeding Disorder ☐Cancer (type:_____) ☐Seizures ☐Diabetes ☐Depression ☐Anxiety ☐Other Psychiatric ☐Suicide ☐Kidney Disease -☐Obesity ☐Rheumatoid Arthritis ☐Lupus ☐Sarcoidosis ☐Psorasis ☐Other Auto Immune Disease

OTHERS?:_____

WOMEN ONLY

Last Menstrual Cycle? _____ Reg?_____ Last Pap?_____ Normal?_____ Birth Control type:_____

SOCIAL HISTORY

1. Do you smoke? (what and how much per week for how long)
2. Do you drink alcohol? (type and how many times per week or per month)

SURGICAL HISTORY

Year	**Surgery**

RECURRING SYMPTOMS (circle)

☐*Depression*	☐*Weight Gain*	☐*Fluid Retention*	☐*Headaches*	☐*Hot Flashes*	☐*Dry skin/Hair*	☐*Anxiety*
☐*Sleep Problems*	☐*Night Sweats*	☐*Problems Climaxing*	☐*Low Libido*	☐*Irritability*	☐*Mood Swings*	☐*Hair Loss*
☐*Arthritis*	☐*Fatigue*	☐*Memory Problems*	☐*Bladder symptoms*	☐*Acne*	☐*Poor concentration /focus*	☐*Constipation*
☐Chest pain	☐Shortness of breath	☐Acid Reflux	☐Rashes	☐*Palpitations*		
MEN ONLY:	☐*Premature ejaculation*	☐*Problems having an erection*				
WOMEN ONLY:	☐*Cystic breasts*	☐*Heavy Menses*	☐*Irregular Menses*	☐*Vaginal Dryness*	☐*Breast Tenderness*	☐*Break through bleeding*
	☐*Menstrual cramps*					
OTHERS:						

_____ _____

Patient Signature and Date Provider Signature and Date