



# Eagle's Landing Family Practice, Inc.

## PATIENT HISTORY AND PHYSICAL FORM

NAME \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_ OCCUPATION \_\_\_\_\_

PHONE: Home \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Work \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Cell \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CHIEF COMPLAINT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

DRUG ALLERGIES:
CURRENT MEDICATIONS:

FAMILY HISTORY						
	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsions						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

HOSPITALIZATIONS OR SURGERIES			
Reason	Date	Reason	Date

**WOMEN ONLY:** Pregnant? \_\_\_ Yes \_\_\_ No Planning Pregnancy? \_\_\_ Yes \_\_\_ No

MEDICAL HISTORY			
<input type="checkbox"/> Headache	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Ulcer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> GI Disorder	<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy/Convulsions
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Lactose Intolerance	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Prostate Disease	<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Bowel Irregularity	<input type="checkbox"/> Depression	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Allergies/Hay Fever	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Gout	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Asthma/Emphysema	<input type="checkbox"/> Sexual/Menstrual Dysfunction	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Cancer	_____

HABITS		
<input type="checkbox"/> <b>Smoke</b> _____ packs daily	<input type="checkbox"/> <b>Coffee</b> _____ cups daily	<input type="checkbox"/> <b>Sleep</b>
How long? _____	<input type="checkbox"/> <b>Other Caffeine</b> _____	<input type="checkbox"/> Difficulty falling asleep
When stopped? _____	<input type="checkbox"/> <b>Alcohol:</b> Type/Amount _____	<input type="checkbox"/> Continuity disturbances
<input type="checkbox"/> <b>Exercise Routine</b> _____	<input type="checkbox"/> <b>Diet:</b> Salt Intake _____	<input type="checkbox"/> Snoring
_____	Fat Intake _____	<input type="checkbox"/> Early morning awakening
<input type="checkbox"/> <b>Contact with blood or body fluid at work</b> _____		
<b>Do you have a Living Will?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		