

Rocky Mountain Family Physicians, P.C.
HISTORY & PHYSICAL

Name _____ SSN _____ Date _____

Address _____ Occupation _____

Phone (home) _____ (work) _____ Date of birth _____ Age _____

Chief complaint _____

DRUG ALLERGIES

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Type of Cancer: _____					
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/ Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDICATIONS

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

- | | | |
|---|--|--|
| <input type="checkbox"/> Hypertension _____ | <input type="checkbox"/> Dizziness/Fainting _____ | <input type="checkbox"/> Ulcer _____ |
| <input type="checkbox"/> Hyperlipidemia _____ | <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> GI Disorder _____ |
| <input type="checkbox"/> Heart palpitations _____ | <input type="checkbox"/> Fatigue _____ | <input type="checkbox"/> Sexual dysfunction _____ |
| <input type="checkbox"/> Heart murmur _____ | <input type="checkbox"/> Shortness of breath _____ | <input type="checkbox"/> Menstrual dysfunction _____ |
| <input type="checkbox"/> Arrhythmia _____ | <input type="checkbox"/> Orthopnea _____ | <input type="checkbox"/> Incontinence _____ |
| <input type="checkbox"/> Chest pain/Angina _____ | <input type="checkbox"/> Allergies/Hay fever _____ | <input type="checkbox"/> Anemia _____ |
| <input type="checkbox"/> MI _____ | <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Stroke/TIAs _____ | <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Claudication _____ | <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Congestive heart failure _____ | <input type="checkbox"/> Venereal disease _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Congenital heart disease _____ | <input type="checkbox"/> Scarlet fever _____ | <input type="checkbox"/> Endocrine disease _____ |
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Rheumatic fever _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Liver disease _____ | <input type="checkbox"/> Other _____ |

WOMEN ONLY: Pregnant? Yes No Planning pregnancy? Yes No

MEN ONLY: It's common for men to occasionally erection difficulties. Is this something that happens to you? Yes No

HABITS

- | | | |
|--|--|--|
| <input type="checkbox"/> Smoking: Packs daily _____
For how long? _____
Interested in stopping? _____ | <input type="checkbox"/> Coffee: Cups daily _____
Other caffeine _____ | <input type="checkbox"/> Sleep Difficulty falling asleep? _____
Continuity disturbances? _____
Snoring? _____ |
| <input type="checkbox"/> Exercise routine: _____ | <input type="checkbox"/> Alcohol: Type _____
Amount _____ | Early morning awakening? _____ |
| _____ | <input type="checkbox"/> Diet Salt intake _____
Fat intake _____ | Daytime drowsiness? _____ |
| _____ | | Other _____ |