Rocky Mountain Family Physicians, P.C.

HISTORY & PHYSICAL

Name ______________________________ SSN ___________________ Date _________________________

Address ____ Occupation ____________________

Phone (home) _______________ (work) ________________ Date of birth ________________ Age _______

Chief complaint ____

DRUG ALLERGIES

____

____

____

____

____

____

CURRENT MEDICATIONS

____

____

____

____

____

____

FAMILY HISTORY

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

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

Hypertension ________________________
Hyperlipidemia ________________________
Heart palpitations ________________________
Heart murmur ________________________
Arrhythmia ________________________
Chest pain/Angina ________________________
MI ________________________
Stroke/TIAs ________________________
Claudication ________________________
Congestive heart failure ________________
Congenital heart disease ________________
Headache ________________________
Epilepsy ________________________

Dizziness/Fainting ________________________
Anxiety ________________________
Fatigue ________________________
Shortness of breath ________________________
Orthopnea ________________________
Allergies/Hay fever ________________________
Asthma ________________________
COPD ________________________
Pneumonia ________________________
Venereal disease ________________________
Scarlet fever ________________________
Rheumatic fever ________________________
Liver disease ________________________

Ulcer ________________________
GI Disorder ________________________
Sexual dysfunction ________________________
Menstrual dysfunction ________________________
Incontinence ________________________
Anemia ________________________
Arthritis ________________________
Osteoporosis ________________________
Gout ________________________
Diabetes ________________________
Endocrine disease ________________________
Other ________________________
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

Smoking: Packs daily ________________
For how long? ________________
Interested in stopping? ________
Exercise routine: ______________________
____
____

Coffee: Cups daily ______________
Other caffeine ___________
Alcohol: Type ______________
Amount ______________
Diet: Salt intake ______________
Fat intake ______________

Sleep: Difficulty falling asleep? ________
Continuity disturbances? ________
Snoring? ______________________
Early morning awakening? ______
Daytime drowsiness? ___________
Other ______________________