FAMILY MEDICAL CENTER

FAMILY MEDICAL CENTER OF LAGUNA HEIGHTS

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HISTORY & PHYSICAL

Name: Date:

Phone: HOME CELL Date of birth: Age:

Email: SS #:

Chief Complaint: Occupation:

DRUG ALLERGIES & REACTION:

No known drug allergies

CURRENT MEDS:

No medications

OVER THE COUNTER MEDS / SUPPLEMENTS:

FAMILY HISTORY:

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

HOSPITALIZATION OR SURGERY:

No prior history of hospitalization/surgery

REASON	DATE	REASON	DATE

MEN ONLY:

When you attempted sexual intercourse, was it satisfactory for you? Yes No

Do you have confidence in keeping your erection during intercourse? Yes No

Colonoscopy Date:

WOMEN ONLY:

Pregnant? Yes No Planning pregnancy Yes No Pap Smear Date

Colonoscopy Date: Memmogram Date:

MEDICAL HISTORY: (Mark each then applies or write N/A for each)

Headache	Bronchities	Sexual/Menstrual dysfunction
Shortness of breath	Pneumonia	Venereal disease
Heart palpitations	Ulcer	Frequent infections
Heart murmur	GI disorder	Hepatitis
Chest pain	Depression	Anemia
Dizziness/zFainting	Gallbladder disease	Arthritis
Peripheral vascular disease	Prostate disease	Osteoporosis
Allergies/Hay fever	Bowel irregularity	Nervousness
Asthma	Incontinence	Other

HABITS

Smoke: Do you smoke? Yes No Have you ever smoked? Yes No How long? How many packs per day? Intrested to quit? Yes No

Exercise: Yes No Routine:

Alcohol: Never Sometimes Socially Amount: Diet: Salt intake Fat intake

Sleep: N/A Difficulty falling asleep Continuity disturbances Snoring Early morning awakening Daytime drowsiness Other

Hepatitis C risk factor: Blood transfusion prior to 1992 IV drug use (1+ times) Contact with blood/bodily fluid