Evansville Multi-Specialty Clinic, PC

812-475-1948 • Toll Free: 1-888-401-4DOC • Fax: 812-401-1267 • www.evvclinic.com
6140 E. Columbia Street, Evansville IN 47715

Confidential History and Physical

Patient Name: _____ **Date**: _____
Last First MI
DOB: _____ Date of last Physical: _____

SYMPTOMS: CHECK ALL SYMPTOMS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

GENERAL
O Chills
O Depression
O Dizziness
O Fainting
O Forgetfulness
O Headache
O Loss of sleep
O Loss of weight
O Nervousness
O Numbness
O Sweats

GASTROINTESTINAL
O Poor Appetite
O Bloating
O Bowel Changes
O Constipation
O Diarrhea
O Excessive Hunger
O Excessive Thirst
O Gas
O Hemorrhoids
O Indigestion
O Nausea
O Rectal Bleeding
O Stomach Pain
O Vomiting
O Vomiting Blood

EYE,EAR,NOSE,THROAT
O Bleeding Gums
O Blurred Vision
O Crossed Eyes
O Difficulty Swallowing
O Double Vision
O Earache
O Ear Discharge
O Hay Fever
O Hoarseness
O Loss of Hearing
O Nosebleeds
O Persistent Cough
O Ringing in Ears
O Sinus Problems
O Vision-Flashes
O Vision-Halos

MEN ONLY
O Breast Lump
O Erection Issues
O Lump in Testicles
O Penis Discharge
O Sore on Penis
O Other_____

WOMEN ONLY
O Abnormal Pap Smear
O Bleeding Between Periods
O Breast Lump
O Extreme Menses Pain
O Hot Flashes
O Nipple Discharge
O Vaginal Discharge
O Other_____
Date of Last Period
_____
Date of Last Mammogram:
_____
Are You Pregnant:_____
Date of Last Pap:_____

MUSCLE/JOINT/BONE
weak/numb/tingle
O Arms O Shoulders
O Back O Legs
O Feet O Neck
O Hands O Hips

GENITO/URINARY
O Blood in Urine
O Frequent Urination
O Lack Of Bladder Control
O Painful Urination

CARDIOVASCULAR
O Chest Pain
O High Blood Pressure
O Irregular Heart Beat
O Low Blood Pressure
O Poor Circulation
O Rapid Heart Rate

SKIN
O Bruise Easily
O Hives
O Itching
O Change in Moles
O Rash
O Scars

CONDITIONS: CHECK ALL CONDITIONS YOU CURRENTLY HAVE HAD IN THE PAST YEAR.

O AIDS
O Alcoholism
O Anemia
O Anorexia
O Appendicitis
O Arthritis
O Asthma
O Bleeding Disorder
O Breast Lump
O Bronchitis
O Bulimia
O Cancer
O Cataracts
O Chemical Dependency
O Chicken Pox
O Diabetes
O Emphysema
O Epilepsy
O Glaucoma
O Goiter
O Gonorrhea
O Gout
O Heart Disease
O Hepatitis
O Hernia
O Herpes
O High Cholesterol
O HIV Positive
O Kidney Disease
O Liver Disease
O Measles
O Migraine/Headache
O Miscarriage
O Mononucleosis
O Multiple Sclerosis
O Mumps
O Pacemaker
O Pneumonia
O Polio
O Prostate Problem
O Psychiatric Care
O Rheumatic Fever
O Scarlet Fever
O Stroke
O Suicide Attempts
O Thyroid Problems
O Tonsillitis
O Tuberculosis
O Typhoid Fever
O Ulcers
O Vaginal Infections
O Venereal Disease

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FAMILY HISTORY

Relation	Age	State of Health	Age/Cause of Death
Father	___	_____	_____
Mother	___	_____	_____
Grandfather	___	_____	_____
Grandfather	___	_____	_____
Grandmother	___	_____	_____
Grandmother	___	_____	_____
Brother	___	_____	_____
	___	_____	_____
Sister	___	_____	_____
	___	_____	_____

Check if they (your relatives) had the following disease:

	Relation to You
O Arthritis, Gout	_____
O Asthma, Hay Fever	_____
O Tuberculosis	_____
O Cancer	_____
O Kidney Disease	_____
O Chemical Depend.	_____
O Diabetes	_____
O Heart Disease, Stroke	_____
O High Blood Pressure	_____
O Other	_____

HORMONES: Are you currently taking or seeking hormone therapy? Circle One YES/NO
Reason: Please Check One: Menopause _____ Low Testosterone _____ Other _____

HOSPITALIZATOINS/SURGERIES:

Year	Circle One	Reason
_____	Hospital/Surgery	_____
_____	Hospital/Surgery	_____
_____	Hospital/Surgery	_____
_____	Hospital/Surgery	_____
_____	Hospital/Surgery	_____

PREGNANCIES:

Year	Sex of Birth	Complications
____	M/F	_____
____	M/F	_____
____	M/F	_____

OCCUPATIONAL EXPOSURE: CHECK ALL THAT APPLY
O Stress O Hazardous Substance
O Heavy Lifting O Other _____
Occupation: _____

Immunization: List Last Date Please
Flu Shot: _____ Tetanus: _____
Pneumonia: _____
FOR CHILDREN PLEASE BRING IMMUNIZATION RECORD.

DIET: Would you consider your diet? Good Fair Poor

Do you drink caffeine?	Yes/No	How many cans/bottles a day? _____
Do you CURRENTLY use tobacco?	Yes/No	What type and how much a day? _____
Do you use illegal drugs?	Yes/No	What and how much a day?_____
Do you drink alcohol?	Yes/No	What type and how much a day? _____
Previous alcohol use?	Yes/No	When did you quit? _____
Previous tobacco use?	Yes/No	When did you quit? _____
Previous illegal drug?	Yes/No	When did you quit? _____

HAVE YOU EVER RECEIVED A BLOOD TRANSFUSION? ____, WHEN _____, WHERE_____

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Are you currently under the care of any other doctor or nurse practitioner? YES NO
If yes, Please list name and reason:

_____
_____
_____

Who is/was your previous provider and why are you leaving them?

_____
_____
_____

MEDICATION/DOSE/DIRECTIONS: "BRING ALL MEDICATIONS IN THE ORIGINAL BOTTLE WITH YOU TO YOUR FIRST APPOINTMENT PLEASE." **I DO NOT TAKE ANY MEDS** _____

Medication Name (including over the counter)	Dose	How Often

if you did not have enough room please continue on separate sheet of paper

ALLERGIES: LIST ALL ALLERGIES FOOD, MEDICATIONS AND POLLUTANTS **I HAVE NONE** ____

Allergy Name (Drug/Food/Pollutant)	Type Of Reaction You Have

if you did not have enough room please continue on separate sheet of paper

I certify that the above information is correct to the best of my knowledge. I will not hold my provider or any members of his/her staff accountable for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ Date: _____
Relation to patient: _____