HISTORY & PHYSICAL

NAME
DATE
ADDRESS
OCCUPATION PHONE (HOME)
(WORK) DATE OF BIRTH
CHIEF COMPLAINT
INSURANCE#

Siskiyou Family Health
1025 Siskiyou Blvd
Ashland, Oregon 97520
Phone: 541-488-0873 Fax: 482-6037

HOSPITALIZATION

DATE	REASON	DATE	REASON

DRUG ALLERGIES

MEDICATIONS

MEDICAL HISTORY

☐ RINGING IN EAR
☐ EAR INFECTIONS - *FREQUENT*
☐ DIZZINESS/FAINTING
☐ FAILING VISION
☐ EYE INFECTIONS
☐ NOSE BLEEDS
☐ SINUS TROUBLE
☐ SORE THROATS - FREQUENT
☐ HAYFEVER/ALLERGIES
☐ PNEUMONIA
☐ BRONCHITIS/CHRONIC COUGH
☐ ASTHMA/WHEEZING
☐ CHEST PAIN
☐ HIGH BLOOD PRESSURE
☐ HEART MURMER
☐ SWOLLEN ANKLES
☐ LEG PAIN - WALKING
☐ VARICOSE VEINS/PHLEBITIS
☐ LOSS OF APPETITE
☐ DIFFICULTY SWALLOWING
☐ INDIGESTION OR HEARTBURN
☐ PERSISTENT NAUSEA/VOMITING
☐ PEPTIC ULCERS
☐ ABDOMINAL PAIN - *CHRONIC*

☐ GALL BLADDER TROUBLE
☐ JAUNDICE/HEPATITIS
☐ CHANGE IN BOWEL HABITS
☐ DIARRHEA ☐ CONSTIPATION
☐ DIVERTICULOSIS ☐ CHROHN'S/COLITIS
☐ BLOODY OR TARRY STOOLS
☐ HEMORRHOIDS
☐ HERNIA
☐ URINE INFECTIONS - FREQUENT
☐ BLOOD IN URINE
URINATION ☐ OVERNIGHT>THAN TWICE
☐ PAINFUL ☐ LOSS OF CONTROL
☐ DECREAS IN FORCE/FLOW
☐ KIDNEY STONES
☐ VENERAL DISEASE
☐ URETHRAL DISCHARGE
☐ CHRONIC FATIGUE
☐ WEIGHT LOSS - *RECENT*
☐ ANEMIA ☐ BRUISE EASILY
☐ CANCER
☐ DIABETES
☐ THYROID DISEASE
☐ CONVULSIONS/SEIZURS
☐ STROKE

☐ TREMOR/HANDS SHAKING
☐ MUSCLE WEAKNESS
☐ NUMBNESS/TINGLING SENSATIONS
☐ HEADACHES - *FREQUENT*
☐ ARTHRITIS/RHEUMATISM
☐ OSTEOPOROSIS
☐ BACK PAIN - *RECURRENT*
☐ BONE FRACTURE/JOINT INJURY
☐ GOUT
☐ FOOT PAIN ☐ COLD NUMB FEET
☐ RASHES ☐ HIVES
☐ PSORIASIS ☐ ECZEMA
☐ NERVOUSNESS ☐ DEPRESSION
☐ MEMORY LOSS
☐ MOODINESS - *EXCESSIVE*
☐ PHOBIAS
☐ MENTAL ILLNESS
☐ LACTOSE INTOLERANCE
☐ PROSTATE DISEASE
☐ SEXUAL/MENSTRUAL DYSFUNCTION
☐ FREQUENT INFECTIONS
☐ DIPHTHERIA
☐ TETANUS

☐ MEASLES ☐ RUBELLA ☐ RHEUMATIC FEVER ☐ SCARLETT FEVER ☐ TUBERCULOSIS ☐ HERPES ☐ CHICKEN POX ☐ POLIO ☐ MUMPS
☐ OTHER ☐ OTHER

FEMALES – *PLEASE COMPLETE*

PREGNANT? ☐ YES ☐ NO PLANNING PREGNANCY? ☐ YES ☐ NO MENTRUAL FLOW: ☐ REGULAR ☐ IRREGULAR ☐ PAIN/CRAMPS
____ DAYS OF FLOW ____ LENGTH OF CYCLE DATE – 1ST DAY OF LAST PERIOD ☐ PAIN/BLEEDING DURING OR AFTER SEX
NUMBER OF: ____ PREGNANCIES ____ ABORTIONS ____ MISCARRIAGES ____ LIVE BIRTHS
BIRTH CONTROL METHOD B.C. PILL (NAME) ☐ FLUSHING/MENOPAUS
DATE OF LAST PAP TEST ☐ NORMAL ☐ ABNORMAL DATE OF LAST MAMMOGRAM ☐ NORMAL ☐ ABNORMAL

FAMILY HISTORY

	FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS
ALCOHOLISM	☐	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐	☐
BLEEDING DISORDER	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐
GLAUCOMA	☐	☐	☐	☐	☐	☐
EPILEPSY/CONVULSIONS	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐

	FATHER	MOTHER	CHILDREN	SIBLINGS	FATHER'S PARENTS	MOTHER'S PARENTS
HIGH BLOOD PRESSURE	☐	☐	☐	☐	☐	☐
KIDNEY DISEASE	☐	☐	☐	☐	☐	☐
MENTAL ILLNESS	☐	☐	☐	☐	☐	☐
MIGRAINE	☐	☐	☐	☐	☐	☐
OSTEOPOROSIS	☐	☐	☐	☐	☐	☐
STROKE	☐	☐	☐	☐	☐	☐
THYROID DISEASE	☐	☐	☐	☐	☐	☐
OTHER						

HABITS

☐ ALCOHOL: TYPE
AMOUNT
☐ COFFEE: CUPS DAILY
OTHER CAFFEINE

☐ DIET: SALT INTAKE
FAT INTAKE
OTHER
☐ EXERCISE ROUTINE

☐ SLEEP: DIFFICULTY FALLING ASLEEP
CONTINUITY DISTURBANCES
EARLY MORNING AWAKENING
DAYTIME DROWSINESS

☐ SMOKE: PACKS
HOW LONG
INTERESTED IN
STOPPING?