Welcome to Woods Cardiovascular Internal Medicine Associates, P.C.

History & Physical Form

Patient Name _____ _____ Date of Birth_____ Today's Date_____

Pharmacy Information:

Name:	Phone #	Fax#
Address :		

Health Maintenance History (list the most recent date for each of the following)

Woman Only	Both Men and Women		Men Only
_____ Menstrual Period	_____Colonoscopy	_____STD Screening	_____Prostate Exam
_____ Mammogram	_____Sigmoidoscopy	_____Fecal Occult Blood	_____PSA
_____ Breast Exam	_____Cholesterol Test	_____Blood Pressure Check	
_____ Pap Smear	_____Flu Vaccine	_____Diabetes Screening	
	_____Zoster Vaccine	_____Eye Exam	
	_____Tdap Vaccine	_____ Foot Exam	
	_____Pneumonia Vaccine		

Medical History (check conditions you have or have had in the past)

__Alcoholism	__Chemical dependence	__Hepatitis	__Psychiatric care
__Anemia	__Diabetes	__Herpes	__Rheumatic fever
__Anxiety	__Depression	__High Blood Pressure	__Seasonal Allergies
__Arthritis	__Eating disorder	__High Cholesterol	__Sexual Difficulty
__Asthma	__Emphysema/COPD	__HIV/AIDS	__Sexually transmitted infection
__Autoimmune disease	__Epilepsy/Seizures	__Kidney disease	__Skin rash
__Bleeding/Clotting disorder	__Erectile dysfunction	__Liver disease	__Sleep apnea
__Bone/Joint disorder	__GERD (reflux)	__Multiple sclerosis	__Stroke
__Breast Lump	__Goiter	__Osteoporosis	__Thyroid problem
__Cancer (see below)	__Gout	__Peripheral vascular disease	__Tuberculosis
__Congestive Heart Failure	__Headaches	__PPD positive	__Urinary incontinence
__CAD/Heart Disease	__Heart attack	__Prostate problem	__Vaginal infection

Other (please describe)

If you have/had cancer, please name type(s) and describe treatment with corresponding dates in the space below:

Date of last physical exam:	Former primary care provider:

Reason for today's visit:

Please describe any symptoms/complaints that you would like to discuss with your primary care provider at today's appointment

Woman Only

Number of pregnancies: Number of living children: Number of abortions: Number of miscarriages:

Date	Type of delivery	Sex	Complications	Date	Type of delivery	Sex	Complications

Patient Name _____ _____ Date of Birth_____ Today's Date_____

Surgical History

Year	Location	Type (please describe any complications)

Other Hospitalizations, serious illnesses, injuries

Year	Location	Reason for hospitalization/Describe Serious Illness or Injury

Health Habits (Check appropriate boxed below and describe)

Caffeine ☐ Yes ☐ No	Number of caffeinated drinks per day:
Tobacco ☐ Yes ☐ No	☐ Cigarettes ☐ Pipe ☐ Cigar ☐ Chewing tobacco Number of years you have used tobacco: Amount per day (i.e. number of packs smoked): Year quit:
Alcohol ☐ Yes ☐ No ☐ Quit	Number of drinks per week: Preferred drink (i.e. beer, wine) Year quit:
Recreational drugs ☐ Yes ☐ No	Type: Amount per week: Last used:
Exercise ☐ Yes ☐ No	Describe type of exercise: Number of days per week:
During the past month, have you felt down, depressed, or hopeless? ☐ Yes ☐ No During the past month have you felt little interest or pleasure in doing things? ☐ Yes ☐ No	

Medications – List all medications, including over the counter medications and supplements. Write dosage and frequency for each medication.

*** Please attach additional sheets if necessary

Allergies

☐ No Known Allergies	☐ Yes, I have the following medication and/or food allergies. Please describe you reaction to each medication/food listed.

Family History

Relation	Age if living	Age of death	Medical conditions/Cause of death
Mother			
Father			
Sisters			
Brothers			

Check if a blood relative has had any of the following. List relationship of relative to you.

☐ Alcoholism/Substance abuse :	☐ High cholesterol:
☐ Autoimmune disorder:	☐ Kidney disease:
☐ Asthma:	☐ Mental illness:
☐ Bleeding/Clotting disorder:	☐ Osteoporosis:
☐ Cancer:	☐ Stroke
☐ Diabetes:	☐ Thyroid problem
☐ Heart disease	Other -
☐ High blood pressure:	

Please list other pertinent information your physician should know:

_____
_____
_____
_____
_____
_____
_____

I attest that the above information is correct to the best of my knowledge.

_____ _____
Signature of patient/Legal guardian/Legal representative Date

_____ _____
Name of legal guardian/Legal representative (Please print) Relationship to patient