

Gahanna Family Practice, Inc.

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History and Physical

Name: _____ SS#: _____ Date: _____
 Address: _____ Occupation: _____
 Phone (home): _____ (work): _____ Date of Birth: _____ Age: _____
 Chief Complaint: _____

Drug Allergies: _____

Current Medications: _____

Surgeries/Hospitalizations (Date/Reason):

| | | | |
|--|---|--|---|
| <p>Past History</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Heart Disease High Blood Pressure Cancer: _____ Diabetes Thyroid Disease Stroke Asthma/emphysema Osteoporosis Depression Seizures/epilepsy Glaucoma Ulcers/abdominal pain Other: _____ Allergies: _____</p> | <p>Family History</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>Who has disease? _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____</p> |
|--|---|--|---|

Habits

Smoke Cigarettes? Yes No #packs/day: _____ Caffeine: coffee: _____ cups/day
 How long? _____ colas: _____ cans/day
 Interested in quitting? Yes No Alcohol: type: _____ amount: _____
 Exercise routine: _____ Diet: low salt? Yes No
 _____ low fat? Yes No

Sleep: insomnia? Yes No
 snoring? Yes No
 daytime drowsiness? Yes No

Women Only

Pregnant? Yes No Total number of pregnancies: _____
 Age at onset of periods: _____ Date of last menstrual period: _____
 Date of last PAP smear: _____ Last mammogram: _____
 History of abnormal PAPs? Yes No

Vital Signs: Temp.: _____ Pulse: _____ Bp: _____ Height: _____ Weight: _____ Resp.: _____