SUNRISE MEDICAL CENTER
HISTORY AND PHYSICAL

NAME: _____ DATE OF BIRTH: _____/_____/_____

Past Medical History

[ ] Asthma
[ ] Rheumatic Fever
[ ] High Cholesterol
[ ] Emphysema
[ ] Irregular Heart Rate
[ ] Anemia
[ ] Tuberculosis
[ ] Arthritis
[ ] Shortness of breath
[ ] Heart Attack
[ ] Ulcer
[ ] COPD
[ ] Heart Palpitations
[ ] TIA
[ ] T.B. Skin Test
[ ] Allergies/Hay Fever
[ ] Blood Clot in legs
[ ] High Blood pressure
[ ] Seizures
[ ] Valley fever
[ ] Congestive Heart Failure
[ ] Stroke
[ ] Hemoptysis
[ ] Heart Murmur
[ ] Angina
[ ] Fluid in Lungs
[ ] Bronchitis
[ ] Headaches
[ ] Dizziness/Fainting
[ ] Pneumonia
[ ] Diabetes
[ ] Chest Pain
[ ] Lung Cancer
[ ] Nervous Breakdown

DRUG ALLERGIES / REACTION

_____
_____
_____
_____

SURGERIES DATE REASON

_____
_____
_____
_____

HOSPITALIZATIONS

DATE REASON

_____
_____
_____

SOCIAL HISTORY

Alcohol Use YES/NO
Alcohol Type? _____
How much daily/monthly? _____
How many years? _____
Tobacco Use (CIRCLE ONE)YES/NO/PAST
How much? Daily/Past? _____
How many years?_____
What year did you stop? _____

Exposures (Circle one)

Have you ever been exposed to the following?
Asbestos? YES/NO
Sandblasting? YES/NO
Toxic Fumes? YES/NO If, yes please explain:

Last Pneumonia shot?_____
Last Flu shot? _____

FAMILY HISTORY

ANY DISEASES THAT RUN IN THE FAMILY?

FATHER (ALIVE/DECEASED/UNKNOWN): _____
MOTHER (ALIVE/DECEASED/UNKNOWN): _____
SPOUSE (ALIVE/DECEASED/UNKNOWN): _____
SON(S) (ALIVE/DECEASED/UNKNOWN): _____
DAUGHTER(S) (ALIVE/DECEASED/UNKNOWN): _____
SIBLINGS (ALIVE/DECEASED/UNKNOWN): _____
[ ] UNKNOWN FAMILY HISTORY [ ] ADOPTED