CareFIRST

HISTORY & PHYSICAL FORM - Page 1 of 3

Name (Print): _____ Date: _____
Last First MI

List your **MAIN COMPLAINTS**: _ _____
_____
_____

Describe your condition (onset, cause, etc.) _____
_____
_____

List the date & type of diagnostic procedures you've had (MRI's, CT, x-rays, etc.) _____
_____

MEDICAL HISTORY & REVIEW OF SYSTEMS

Do you have or had any of the following?

Transmissible Disease(s): ❒ None ❒ Hepatitis A-B-C ❒ HIV ❒ TB

Neurological: ❒ Headaches ❒ Stroke ❒ Epilepsy ❒ Aneurysm ❒ Other _____

Cardiovascular: ❒ Chest Pain ❒ Hypertension ❒ Heart Disease ❒ Other _____

Respiratory: ❒ Lund Disease ❒ Asthma ❒ Shortness of Breath ❒ Other _____

Are you a smoker? ❒ No ❒ Yes # of years_____-# of packs per day_____

Gastrointestinal: ❒ Ulcer ❒ Hernia ❒ Hysterectomy ❒ Other _____

Musculoskeletal: ❒ MSD ❒ Arthritis ❒ Neck or Back Pain ❒ Other _____

Metabolic: ❒ Liver Disease ❒ Thyroid Disease ❒ Bleeding Disorder ❒ Cancer/Type_____
❒ Diabetes___Meds___Insulin ❒ Other_____

Genito-Urinary: ❒ Kidney Disease ❒ Painful Urination ❒ Frequent Urination
❒ Possible Pregnancy ❒ Sexual Dysfunction ❒ Other _____

E.E.N.T.: ❒ Blindness ❒ Cataracts ❒ Glaucoma ❒ Vision Difficulty ❒ Deaf
❒ Swallowing Problems ❒ Nose Bleeds

Psychological: ❒ Anxiety ❒ Depression ❒ Fatigue ❒ Nervousness ❒ Other _____

PREVIOUS HOSPITALIZATIONS/SURGERIES (LIST TYPE AND YEAR)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

❒ See Attached

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HISTORY & PHYSICAL FORM - Page 2 of 3

MEDICATIONS YOU ARE CURRENTLY TAKING

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____
9. _____ 10. _____

❒ See Attached

LIST ALLERGIES

1. _____ 2. _____
3. _____ 4. _____

❒ See Attached

SOCIAL HISTORY

EMPLOYER:_____ Hours worked per week _____

JOB DUTIES:_____

1. USE OF ALCOHOL ❒ Never ❒ Rarely ❒ Moderate ❒ Daily

2. USE OF DRUGS ❒ Yes ❒ No Type_____

3. SLEEP HABITS ❒Good ❒ Intermittent ❒Poor

4. EXERCISE ❒ Never ❒Intermittent ❒ Frequent

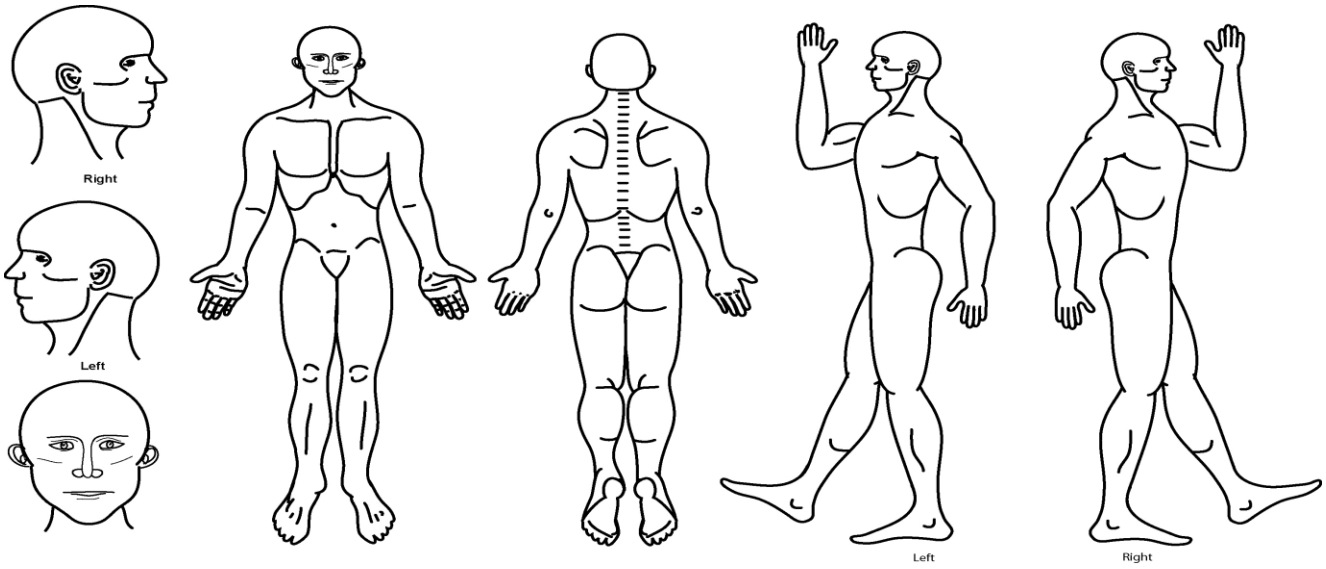
5. LEISURE/HOBBIES:_____

6. EDUCATION ❒ High School/G.E.D ❒ College _____# of Years

FAMILY MEDICAL HISTORY

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Sibling(s)			
Spouse			
Children			

Shade your area(s) of pain on the figures below:



Review the information contained in the following table. Circle the number on the left that best describes your pain level today.

0	Pain Free	No medication needed
1	Very minor annoyance – occasional minor twinges	No medication needed
2	Minor annoyance – occasional strong twinges	No medication needed
3	Annoying enough to be distracting	Mild painkillers are effective. (Aspirin, Ibuprofen, Aleve)
4	Can be ignored if you are really involved in your work, but still distracting	Mild painkillers relieve pain for 3-4 hours
5	Can't be ignored for more than 30 minutes	Mild painkillers reduce pain for 3-4 hours
6	Can't be ignored for any length of time, but you can still participate in some activity.	Strong painkillers (Codeine, Vicodin, Hydrocodone) reduce pain for 3-4 hours
7	Makes it difficult to concentrate, interferes with sleep. You can still function with effort.	Stronger painkillers are only partially effective. Strongest painkillers relieve pain (OxyContin, Morphine)
8	Physical activity is severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.	Stronger painkillers are minimally effective. Strongest painkillers reduce pain for 3-4 hours.
9	Unable to speak. Crying out or moaning uncontrollably – Near delirium.	Strongest painkillers are only partially effective.
10	Unconscious. Pain makes you pass out	Strongest painkillers are only partially effective.

Check the box which most accurately describes the frequency of your pain (Percentage of Time in Pain):

❒ Intermittently (25%) ❒ Occasionally (26-50%) ❒ Frequently (51-75%) ❒ Constantly (100%)

Signature _____ Date: _____