Family Psychiatric Services, LLC

Patient Physical Form

NAME _____ Date _____/ _____/ _____

D.O.B. _____/ _____/ _____ AGE _____

A. REVIEW OF SYSTEMS:		
YES	NO	GENERAL
		1. Is your health generally good?
		2. Unexplained weight loss or gain of more than 10 lbs. in the past year?
		3. Night sweats / hot flashes?
		4. Cancer? If yes, where / when?
		5. Tobacco use? If yes, for how many years? _____ If yes, ☐ smoking? How many/day? ____ ☐ chewing tobacco?
		6. Alcohol use? If yes, how many drinks/week?
		7. Are you being treated for any illness/condition now? If yes what?
		8. Do you currently take medicine: prescription, over-the-counter, or herbal? If yes, what? Do you take any folic, vitamin, or nutritional acid supplements?
		9. Birth defects or genetic problems?
		10. Eye problems (except glasses or contacts)?
		11. Hearing problems?
		12. Frequent nosebleeds?
		13. Frequent sore throat?
CARDIORESPIRATORY		
		14. Mitral valve prolapse?
		15. Heart murmur?
		16. Varicose veins?
		17. Blood clots (head / leg / lungs)?
		18. Stroke or stroke-like problems?
		19. High blood pressure?
		20. High cholesterol?
		21. Chronic cough or other breathing problems / asthma?
		22. Tuberculosis or exposure to tuberculosis?
GASTROINTESTINAL		
		23. Stomach or bowel problems?
		24. Liver problems (hepatitis or tumor, etc.)?
		25. Gallbladder problems?
GENITOURINARY		
		26. Bladder, urine leaks, or kidney problems?
		27. Uterine fibroids?
		28. Ovarian cysts?
		29. Endometriosis?
		30. ☐ Arthritis? ☐ Osteoporosis? ☐ Other?
SKIN		
		31. Acne or other skin problems? If yes, what?
NEUROLOGICAL		
		32. Migraine headaches / Aura (diagnosed by MD / NP / PA)?
		33. Seizures / epilepsy?
		34. Numbness in arms / legs (recurring)?
PSYCHOLOGICAL		
		35. Have you ever been hospitalized due to mental illness? ☐ Yes ☐ No Have you ever considered suicide? ☐ Yes ☐ No

A. (cont'd) REVIEW OF SYSTEMS:		
YES	NO	ENDOCRINE
		41. Thyroid problems?
		42. Diabetes?
HEMATOLOGICAL/LYMPHATIC		
		43. Anemia (Low Iron)?
		44. Sickle cell disease / trait?
		45. Blood clotting disorder?
ALLERGY		
		46. Are you allergic to any drug, medication, latex, or other substance, including local anesthesia? If yes, to what? Type of reaction:

B. HOSPITALIZATION AND SURGERIES

Year	Reason

D. FAMILY HISTORY

Are you adopted? ☐ Yes ☐ No

Have your biological family (parents, brothers, sisters) had any of the following?

YES	NO	Diagnosis Relative	
		Osteoporosis?	
		Diabetes?	
		Heart disease / heart attack / stroke before age 50?	
		High blood cholesterol?	
		Genetic problems?	
		Cancer? If yes, please specify Blood clots?	
		Other?	

MENSTRUAL HISTORY

1. Age periods began?
2. Length of period? (days) # of days between periods?
3. Are your periods usually regular? ☐ Yes ☐ No
4. Last period started on It seemed ☐ Normal ☐ Not normal
5. Do you experience, before or with periods, ☐ Cramps? ☐ Bloating?
   ☐ Bowel problems? ☐ Emotional changes?
7. Do you have vaginal bleeding between menstrual periods? ☐ Yes ☐ No

ADDITIONAL COMMENTS / EXPLANATIONS (by number)

		Height:
		Weight:
		Recent Blood Pressure:

Current Medications/Supplements:

To the best of my knowledge the information I have provided is correct and complete.

Patient Signature	Date
Staff Signature	Date

History reviewed:

Staff Signature	Date
Staff Signature	Date