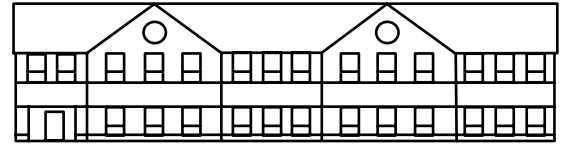


Family Physicians of Gahanna, Inc.
 535 Offcenter Pl. • Gahanna, Ohio 43230
 (614) 471-9654 • fax (614) 471-9634
 www.fpoginc.com • info@fpoginc.com



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):

Date of last tetanus: _____ Date of hepatitis vaccine or disease : _____
 Date of last flu shot: _____ Date of chicken pox vaccine or disease : _____
 Date of pneumonia shot: _____

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