

History & Physical

Avtar Robert Moore, D.O.
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Lexington, VA 24450

Date: _____ Account#: _____

PATIENT INFORMATION

Name _____ Soc.Sec.# _____

Address _____ Home Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Age _____ Date of Birth _____ Single Married Widowed Separated Divorced

Spouse/Significant Other _____ How long in present relationship _____

Patient Employed by _____ Business Phone _____

Whom may we thank for referring you? _____ Email _____

What is/are your reason(s) for an appointment? _____

HISTORY

CHIEF COMPLAINT _____

History of Chief Complaint/Present Illness:

Location _____ Quality _____
(Where is the pain/problem?) (Example: color of sputum)

Severity _____ Duration _____
(How severe, on a scale of 1-10, is the pain/problem?) (When did the pain/problem start, how long have you had it?)

Timing _____ Content _____
(Does this pain/problem occur at a specific time/situation?) (What were you doing at the onset of pain/problem?)

Associated signs/symptoms _____ Modifying factors _____
(What other associated problems have you been having?) (What makes pain/problem better/worse? Any previous episodes?)

MEDICAL HISTORY

Diabetes.....No	Yes	Previous Hospitalizations/Surgeries/Serious Injuries	When?
Hypertension.....No	Yes	_____	_____
Cancer.....No	Yes	_____	_____
Stroke.....No	Yes	_____	_____
Heart trouble.....No	Yes	_____	_____
Arthritis/gout.....No	Yes	_____	_____
Convulsions.....No	Yes	Medications presently taking(over the counter, vitamins, herbs, remedies):	_____
Bleeding tendency.....No	Yes	_____	_____
Acute infections.....No	Yes	_____	_____
Venereal disease.....No	Yes	_____	_____
Hereditary defects.....No	Yes	_____	_____

NAME _____ ALLERGIES: _____

PAST SURGERIES:

- | | | |
|--|---|---|
| <input type="checkbox"/> Abortion | <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Heart/Valve | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Hemorrhoid | <input type="checkbox"/> Tubes Tied |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Hernia | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Cataract/Eye | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Vasectomy |
| <input type="checkbox"/> Colon/Bowel | <input type="checkbox"/> Lung | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> D and C | <input type="checkbox"/> Mole/Skin Cancer | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Fracture Repair | <input type="checkbox"/> Prostate | |
| | <input type="checkbox"/> Sinus/Nose | |

OTHER HOSPITALIZATIONS: _____

SIGNIFICANT INJURIES/ACCIDENTS/FRACTURES/COMPLICATIONS WITH YOUR BIRTH: _____

FEMALES – PREGNANCY/DELIVERY COMPLICATIONS: _____

SPECIAL STUDIES OR LABS YOU HAVE HAD: _____

FAMILY HISTORY:

MOTHER: alive? Yes_ No Age: _____ Cause of Death: _____

Illnesses: _____

Illnesses that run on this side of the family: _____

FATHER: alive? Yes No Age: _____ Cause of Death: _____

Illnesses: _____

Illnesses that run on this side of the family: _____

Number of Siblings and Ages: Brothers: ____/____ Sisters: ____/____

Any deceased and cause: _____

Illnesses of any siblings: _____

Number of Children and Ages: Sons: ____/____ Daughters: ____/____

Illnesses of children: _____

LIFE STYLE:

Alcohol intake (per week): _____

Tobacco Usage (per day): _____

Caffeine Intake (all types/day): _____

Quality of Nutrition: _____

Hobbies/Recreation: _____

Exercise (type): _____

Occupation: _____

Religious Preference: _____

Other Bodywork/Therapies: _____

Pets: _____

Education: _____

Past Military: _____

I AUTHORIZE TREATMENT FOR MYSELF AND/OR DEPENDENTS BY MY SIGNATURE BELOW

SIGNATURE: _____ DATE: _____