GFP

GENEVA FAMILY PRACTICE

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COMPREHENSIVE HISTORY AND PHYSICAL

Today's date _____

Name _____ **Age** _____ **Date of birth** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Home phone _____ **Cell phone** _____ **E-mail** _____

DRUG ALLERGIES

_____
_____
_____

CURRENT MEDS/SUPPLEMENTS

_____
_____
_____

FAMILY MEDICAL HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Seizures	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Thyroid disease	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

WOMEN ONLY

Pregnant? ___Y ___ N

Last pap?

_____

Last mammogram?

_____

IMMUNIZATIONS

☐ **PNEUMOVAX**
_____
☐ **FLU**_____
☐ **TETANUS** _____
☐ **SHINGLES** _____

HOSPITAL STAYS OR SURGERIES — DATE OF STAY/PROCEDURE

_____
_____
_____

☐ Do you smoke? ___ Yes ___ No
How long? _____
Packs per day? _____

☐ Drink alcohol? ___ Yes ___ No
How often? _____
_____

PERSONAL MEDICAL HISTORY

☐ Headache	☐ Blood in stool	☐ Arthritis
☐ Shortness of breath	☐ Bowel irregularity	☐ Osteoporosis
☐ Heart palpitations	☐ Lactose intolerance	☐ Anxiety
☐ Heart murmur	☐ Gallbladder disease	☐ Depression
☐ Chest pain	☐ Prostate disease	☐ Gout
☐ Dizziness/Fainting	☐ Overnight urination >2x	☐ Stroke
☐ Allergies	☐ Incontinence	☐ Rheum Fever
☐ Bronchitis	☐ Sexually Transmitted Disease	☐ Ulcer
☐ Pneumonia	☐ Frequent infections	☐ GI disorder

☐ Other _____
_____
_____

☐Difficulty falling asleep? ___ Yes ___ No
☐ Fatigue? ___ Yes ___ No
☐ Snoring? ___ Yes ___ No