ensemble RECOVERY
A community of hope and healing

HISTORY AND PHYSICAL

Name _____ SS# _____ Date _____

Address _____ Occupation _____

Phone (Home) _____ (Work) _____ Birth Date _____

Chief Complaint _____

DRUG ALLERGIES

_____

_____

_____

CURRENT MEDS

_____

_____

_____

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FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart disease	❑	❑	❑	❑	❑	❑
Highblood pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding disorder	❑	❑	❑	❑	❑	❑
Kidney disease	❑	❑	❑	❑	❑	❑
Mental illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

PAST MEDICAL HISTORY

- ❑ Headache
- ❑ Shortness of breath
- ❑ Heart palpitations
- ❑ Heart murmur
- ❑ Chest pain
- ❑ Dizziness/fainting
- ❑ Peripheral vascular disease
- ❑ Allergies/Hay fever
- ❑ Asthma
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Ulcer
- ❑ GI disorder
- ❑ Lactose intolerance
- ❑ Gall Bladder disease
- ❑ Prostate disease
- ❑ Bowel Irregularity
- ❑ Incontinence
- ❑ Sexual/Mentrual dysfunction
- ❑ Venereal disease
- ❑ Frequent infections
- ❑ Hepatitis
- ❑ Anemia
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Nervousness
- ❑ Depression
- ❑ Gout
- ❑ Scarlet fever
- ❑ Chronic rashes
- ❑ Rheumatic fever
- ❑ Mumps
- ❑ Measles
- ❑ Rubella
- ❑ Polio
- ❑ Diptheria
- ❑ Tetanus

SOCIAL MEDICAL HISTORY

- ❑ Smoke: Packs daily _____ How Long _____ When Stopped _____
- ❑ Exercise routine _____ ❑ Coffee: Cups daily ___ ❑ Other caffeines _____
- ❑ Alcohol: Type/Amt _____ ❑ Diet: Salt intake ___ ❑ Fat Intake _____
- ❑ Sleep: Difficulty falling asleep ___ ❑ Snoring _____ ❑ Early morning awakening
- ❑ Continuity disturbances
- ❑ Daytime drowsiness
- ❑ Contact with blood or body fluid at work

Form No. 006-011 (9/96)

Patient Information

Patient Name (Last, First, MI)	**Marital Status M W S D**	**M**	**F**	**D.O.B.**	**AGE**	**SS#**
Street Address	**City, State, Zip**					**Phone 1**
Employer	**Occupation (indicate if student)**					**Work Phone**
Spouse or Guardian's Name (Insurance Holder)				**D.O.B.**	**SS#**	
Street Address	**City, State, Zip Code**				**Phone**	
Spouse/ Guardian's Employer	**Occupation (indicate if student)**				**Work Phone**	
Name of Your Pharmacy:	**Name of Family Doctor**				**Other Doctors Who See You**	
In Case of Emergency Notify:	**Phone**				**Alt. Phone**	
Do You Have a Living Will? Yes / No	**Does anyone have a "Durable power of Attorney for Healthcare" for you? Yes / No**				**Name and Phone if 'Yes'**	
Primary Insurance Company	**Secondary Insurance Company**				**Third Insurance Company**	
Which Employer Carries the Above Insurance?	**Which Employer Carries the Above Insurance?**				**Which Employer Carries the Above Insurance?**	

Workman's Compensation / Auto Accident Information

Where you injured on the job? Yes / No	**Date of Injury**	**Workman;s Comp. Claim #**
Workman's Comp. Ins. Company	**Street Address**	**City, State, Zip Code**
Where you injured in an auto accident? Yes / No	**Date of Accident**	**Name of Attorney**