

Physical History Review  
**The Light Clinic**

Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

What concerns do you want to discuss at your appointment today: \_\_\_\_\_

**Allergies:**

**Medications:**

**Vaccination History/ Date:**

		Tetanus:
		Pneumonia:
		Flu:
		Hepatitis A:
		Hepatitis B:
		TB Skin Test:

**Gyn History**

Date of Last Period: \_\_\_\_\_ Have you gone through Menopause:  Yes /Age \_\_\_\_\_  No

**When were your Last Tests?**

	Date		Date
Last PAP Smear: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Performing Doctor:		Colonoscopy / Sigmoidoscopy: Performing Doctor:	
Mammogram: Screening/Diagnostic Facility:		Diabetic: Last Eye Exam Performing Doctor:	
Bone Density:		Diabetic: Last A1C: _____	
Coumadin Check:		Diabetic: Last Fasting Glucose Level: _____	
Heart (List Test): Performing Doctor:		PSA Level: _____ Performing Doctor:	

**Social History**

- Alcohol – Servings per Day/Week: \_\_\_\_\_  Exercises regularly- Days per Week: \_\_\_\_\_  
 Caffeine—Servings per Day/Week: \_\_\_\_\_  Sedentary  
 Cigarette Smoking: pack daily: \_\_\_\_\_ Years  Other:  
Smoked: \_\_\_\_\_

**Please list any Operations or Hospitalizations you have had**

Surgery / Reason	Date	Surgery / Reason	Date