Dr. O. K.

Patient History and Physical Form

Date: DD/MM/YY

Full Name: OHIP #:

Date of Birth: Full Address:

Occupation: Email Address:

Phone – Home: Work: Cell:

Emergency Contact: Phone Number:

Previous Family Doctor: Reason for Leaving:

Drug Allergies	Current Medication

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Hospitalizations or Surgeries

Reason	Date	Reason	Date

Medical History

PLEASE CHECK WHICH APPLY

☐ Headache	☐ Pneumonia	☐ Diabetes	☐ Rheumatic Fever
☐ Shortness of Breath	☐ Ulcer	☐ Hepatitis	☐ Glaucoma
☐ Heart Palpitations	☐ GI Disorder	☐ Anemia	☐ Epilepsy/Convulsions
☐ Heart Murmur	☐ Lactose Intolerance	☐ Arthritis	☐ Bleeding Disorder
☐ Chest Pain	☐ Gallbladder Disease	☐ Osteoporosis	☐ Kidney Disease
☐ Dizziness/Fainting	☐ Prostate Disease	☐ Depression	☐ Thyroid Disease
☐ Peripheral Vascular Disease	☐ Sexual/Menstrual Dysfunction	☐ Hypertension (High Blood Pressure)	☐ Mental Illness
☐ Allergies/Hay Fever	☐ Incontinence	☐ Gout	☐ Other (Specify Below)
☐ Asthma/Emphysema	☐ Bowel Irregularity	☐ Stroke	
☐ Bronchitis	☐ Venereal Disease	☐ Cancer	

Mental Health

Treated for emotional problems?	Yes ◯	No ◯	Date(s):
Considered/Attempted Suicide?	Yes ◯	No ◯	Date(s):
Neurological/Psychological Problems?	Yes ◯	No ◯	

Date of Last

Chest X-Ray:		ECG:	
Blood Tests:		Eye Exam:	
Colon Exam:		TB Test:	
Stool for Blood:		HIV Test:	
Mammogram:		PAP:	
Prostate Exam:		Other:	

Immunization Received (Past 10 Years)

Tetanus ☐	Flu ☐	Pneumonia ☐	Hepatitis A ☐	Hepatitis B ☐	Other:

Childhood Immunization

Mumps Measles Rubella (German Measles) ☐	Polio Pertussis Diphtheria Tetanus ☐

Habits

☐ Smoke
Packs daily:
How long?
When stopped?

Sleep
☐ Difficulty falling asleep
☐ Continuity Disturbances
☐ Snoring
☐ Early morning awakening

☐ Coffee ____ cups daily.
☐ Other Caffeine:
☐ Alcohol (Type/Amount):
Diet -- Salt Intake: Fat Intake:

Sexually Active? Yes ◯ No ◯	# of partners:
Sex of partners? M ☐ F ☐	Fear of partner/other violence? Yes ◯ No ◯

Contact with blood or body fluid at work:

Do you have a Living Will? Yes ◯ No ◯

WOMEN ONLY: **Pregnant? Yes ◯ No ◯ Planning Pregnancy? Yes ◯ No ◯**

Age at first period:	Last menstrual period: