GHP
Grand Health
PARTNERS

General Physical Form

To be completed by the patient

Today's Date: _____

Name: _____ DOB: _____
First Middle Last

Primary Care Physician (PCP): _____ Office Phone #: _____

Preferred Pharmacy: _____ Phone #:_____ Fax #: _____

Pharmacy Address:_____
City State Zip

Other Physician(s): Ex: Cardiologist, GI etc.

Providers Name: _____ Office Phone #: _____

Providers Name: _____ Office Phone #: _____

Providers Name: _____ Office Phone #: _____

Past & Current Medical Diagnosis (Check all that apply)

- ☐ High Blood Pressure
- ☐ Coronary Artery Disease
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Arthritis
- ☐ Depression
- ☐ Diabetes Mellitus Type 2
- ☐ Arrhythmia
- ☐ Lung Disease
- ☐ Seizures
- ☐ Polycystic Ovarian Disease
- ☐ Diabetes Mellitus Type 1
- ☐ Congestive Heart Failure
- ☐ Liver Disease
- ☐ Blood Clots
- ☐ Stroke
- ☐ Anxiety
- ☐ Reflux Disease/GERD
- ☐ Obstructive Sleep Apnea
- ☐ Bleeding Tendencies
- ☐ Peptic Ulcer Disease
- ☐ Hypothyroidism

Other:_____

Other:_____

Other:_____

Prior Surgeries

Type: _____ Date of Operation:_____

Type: _____ Date of Operation:_____

Type: _____ Date of Operation:_____

Type: _____ Date of Operation:_____

Type: _____ Date of Operation:_____

Past problems with Anesthesia (Please describe in detail):_____

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Will you accept a blood Transfusion (if necessary)? YES or NO

PATIENT LAST NAME: _____

Current Medications

(List Current Prescriptions)

1._____	Dose:_____	Time/Day_____
2._____	Dose:_____	Time/Day_____
3._____	Dose:_____	Time/Day_____
4._____	Dose:_____	Time/Day_____
5._____	Dose:_____	Time/Day_____
6._____	Dose:_____	Time/Day_____
7._____	Dose:_____	Time/Day_____
8._____	Dose:_____	Time/Day_____
9._____	Dose:_____	Time/Day_____
10._____	Dose:_____	Time/Day_____

Please list any Dietary Supplements, Herbs, or Vitamins you are currently taking:

1. _____ 2_____ 3. _____4._____

Medical Allergies

Medication Name/Reaction:

1._____ 2._____

3._____ 4. Food Allergies: _____

Family Medical History

(Describe Medical Diagnosis, Weight History)

Father: Alive or Deceased (circle one)	Medical Problem: _____	Medical Problem: _____
Mother: Alive or Deceased (circle one)	Medical Problem: _____	Medical Problem: _____
Siblings: # Brothers____ # Sisters____	Medical Problem: _____	Medical Problem: _____
Children: # Children ____	Medical Problem: _____	Medical Problem: _____

Social History

Are you currently employed? YES or NO Are you currently Disabled? YES or NO Why? _____

Current Employer (if employed) _____ Position: _____

Marital Status:(check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PATIENT LAST NAME: _____

Social History Cont.

Caffeine - Regular Pop: Quantity_____ Diet Pop: Quantity_____ Coffee: Quantity_____ Tea: Quantity_____

Alcohol Consumption: # of Drinks per week ☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ More than 20 a week

Smoking: ☐ Never ☐ Current **Chewing Tobacco**: ☐ Never ☐ Current

Drug Use: Current or Past (circle one), what type: _____ Medical Marijuana Card? YES or NO

Are you currently involved in an exercise program? (Please describe) _____

Previous Medical Testing

Have you had any recent labs done? YES or NO, If yes: Date _____and location_____

Sleep Study	Date: _____	Doctor: _____	C-pap? YES or NO	C-Pap setting _____
Echocardiogram	Date: _____	Doctor: _____	Results: _____	
Heart Stress Test	Date: _____	Doctor: _____	Results: _____	
Heart Catheterization	Date: _____	Doctor: _____	Results: _____	
Breathing Test (PFT's)	Date: _____	Doctor: _____	Results: _____	
Upper Endoscopy (EGD)	Date: _____	Doctor: _____	Results: _____	
Colonoscopy	Date: _____	Doctor: _____	Results: _____	
Ultrasound of Gallbladder	Date: _____	Doctor: _____	Results: _____	
DEXA Scan	Date: _____	Doctor: _____	Results: _____	
Mammogram	Date: _____	Doctor: _____	Results: _____	
Pap & Pelvic exam (women)	Date: _____	Doctor: _____	Results: _____	
Prostate exam (men)	Date: _____	Doctor: _____	Results: _____	

OVER

PATIENT LAST NAME: _____

Current Medical Conditions

(Check all that apply)

General		**Neurological**		**GU**	
	Fever		Numbness		Urine Incontinence
	Chills		Tingling		Painful Urination
	Night Sweats		Weakness		Blood in Urine
	Fatigue		Fainting		Hesitancy
HEENT		**Hematological**			Night-time Urination
	Headaches		Easy Bruising	**Abdominal**	
	Vision Changes		Easy Bleeding		Pain
	Dizziness		Blood Clots		Nausea
Skin		**Musculoskeletal**			Vomiting
	Rash		Joint Pain or Swelling		Diarrhea
	Jaundice		Muscle Pain		Constipation
	Ulcers (leg or sacrum)	**Cardiac**			Bloody Stool
Pulmonary			Chest Pain		Heartburn/Reflux
	Cough		Palpitations		Difficulty Swallowing
	Wheezing		Shortness of Breath w/ Activity	**Endocrine**	
	Snoring		Shortness of Breath w/o Activity		Abnormal Hair growth
	Daytime Sleepiness		Waking up short of breath		High Blood Sugar
	Stop breathing in sleep		Leg Swelling		Thyroid Problems

Any additional medical information you want GHP to know: _____

_____

_____

PLEASE REMEMBER IF YOU'VE HAD AN EKG, EGD, LABS DRAWN, OR CARDIAC TESTS DONE PLEASE BRING THE RESULTS WITH YOU TO YOUR APPOINTMENT.