

Initial Clinical History and Physical Form

Date: _____

Patient Information

Name: _____ Age: _____ Date of Birth: ____/____/____

Race: Caucasian African American Asian Hispanic Multi-Racial Other _____

Sex: Male Female **Marital Status:** Single Married Divorced Widowed # Children _____

Previous Family Physician: _____ Referring Physician: _____

Reason for Visit: _____

Past Medical History

(Please check all conditions that you have or have had.)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Anxiety | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Allergy: Food |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Bleeding Difficulties | <input type="checkbox"/> Seizure | <input type="checkbox"/> Allergy: Seasonal |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis A B or C | <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> TB |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> HIV | <input type="checkbox"/> Arthritis (Type) _____ | <input type="checkbox"/> Hypothyroid |
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Diabetes-Diet Controlled | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hyperthyroid |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Diabetes-Oral Meds | <input type="checkbox"/> Emphysema | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes-On Insulin | <input type="checkbox"/> Osteoporosis | |

Cancer: Type/Treatment: _____

Other (Specify): _____

Past Surgical History

(Type of Surgery & Year)

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____

Prescription Medications

Medication Dose/Number per Day
1. _____

Medication Dose/Number per Day
4. _____

2. _____

5. _____

3. _____

6. _____

Non-Prescription Medications

Medication Dose/Number per Day
1. _____

Medication Dose/Number per Day
4. _____

2. _____

5. _____

3. _____

6. _____

Patient Name: _____

Drug Allergies /Type of Reaction

- No known drug allergies 1. _____ 3. _____
- Latex
- Tape 2. _____ 4. _____

Social History

(Please check the appropriate listings)

Tobacco Use

- Never
- Quit/When? _____
- Cigarettes/Pack per Day? _____
- Pipe
- Cigars
- Chewing Tobacco

How many years? _____

Alcohol Use

- None
- Socially
- Daily
- Heavy

Have you ever been treated for alcoholism?

- Yes No
- If yes, when? _____

Drug Use

- None
- Marijuana
- Amphetamines
- Other _____

Have you ever been treated for drug use?

- Yes No
- If yes, when? _____

Exercise

- None
- 1-2x/week
- 3-4x/week
- 5-7x/week

Type: _____

Caffeine Use

- None
- Occasional
- Daily

How much? _____

Any religious beliefs that would affect your medical care? _____

Education

(Please check highest level)

- Grade School High School College Post Graduate

Occupational History

Employer: _____ Job Title: _____

Have you altered your job as a result of the problem you brought here today? Yes No

If yes, please explain: _____

If you're currently off work as a result of the problem, how long have you been off? _____

Family History

Father	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Age: _____	Medical History or Cause of Death	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Other _____
Mother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Age: _____	Medical History or Cause of Death	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Other _____
Brothers	# Living _____ # Deceased _____	Age: _____	Medical History or Cause of Death	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Other _____
Sisters	# Living _____ # Deceased _____	Age: _____	Medical History or Cause of Death	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Other _____

Patient Name: _____

For Females:

Are you pregnant? _____ Are you breast feeding? _____ # of Pregnancies/Deliveries: _____ Type of Birth Control: _____

Date of first menstrual period: _____ Date of last menstrual period: _____

Last Mammogram: _____ Last Pap: _____ Last Bone Density Scan: _____

For Males:

Do you experience impotency? _____ Erectile Problems: _____

Immunizations:

Flu Date: _____ Pneumonia Date: _____ Tetanus Date: _____

Other:

Screenings: _____ Colonoscopy Date: _____