



Initial Clinical History and Physical Form

Date: _____

Patient Information

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

Race: Caucasian African American Asian Hispanic Other _____

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

Previous Family Physician: _____ Referring Physician: _____

Reason for Visit: _____

Prescription Medications

| <u>Medication</u> | <u>Dose/Number per Day</u> |
|-------------------|----------------------------|
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Non-Prescription Medications

| <u>Medication</u> | <u>Dose/Number per Day</u> |
|-------------------|----------------------------|
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Patient Name: _____

Past Medical History

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

- None
- Anxiety
- High Cholesterol
- Allergy: Food
- Heart Disease
- Bleeding Difficulties
- Seizure
- Allergy: Seasonal
- High Blood Pressure
- Hepatitis A, B or C
- TB
- Loss of Consciousness
- Stroke/TIA
- HIV
- Arthritis (Type) _____
- Obstructive Sleep Apnea
- Diabetes (Diet Controlled)
- Diabetes (Oral Medications)
- Diabetes (Injectable Insulin)
- Asthma
- Hyperthyroid
- Hypothyroid
- Emphysema
- Coronary Artery Disease
- Depression
- Osteoporosis
- Cancer: Type/Treatment _____
- Other (Specify): _____

Drug Allergies/Type of Reaction

- No Known Drug Allergies
- Latex
- Tape (Adhesive)
- 1. _____
- 2. _____
- 3. _____
- 4. _____

For Females:

Are you pregnant? _____ Are you Breastfeeding? _____ # of Pregnancies/Deliveries: _____
Type of Birth Control: _____ Year/Age of First Menstrual Period: _____ Last Pap: _____
Date of Last Menstrual Period: _____ Last Mammogram: _____ Last Bone Density Scan: _____

For Males:

Do you experience impotency? _____ Erectile Problems? _____

Patient Name: _____

Past Surgical History

| <u>Date</u> | <u>Type of Surgery</u> | <u>Date</u> | <u>Type of Surgery</u> |
|-------------|------------------------|-------------|------------------------|
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Hospitalizations

| <u>Date</u> | <u>Reason</u> | <u>Facility</u> |
|-------------|---------------|-----------------|
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Family History

| | | | | |
|----------|--|-----------|-----------------------------------|---|
| 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 _____ |
| 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 _____ |
| 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: _____

Social History

(Please check the appropriate listings)

| <u>Tobacco Use</u> | <u>Alcohol Use</u> | <u>Drug Use</u> | <u>Exercise</u> | <u>Caffeine Use</u> |
|---|--|--|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Never | <input type="checkbox"/> None | <input type="checkbox"/> None | <input type="checkbox"/> None | <input type="checkbox"/> None |
| <input type="checkbox"/> Quit/When? _____ | <input type="checkbox"/> Socially | <input type="checkbox"/> Marijuana | <input type="checkbox"/> 1-2x/week | <input type="checkbox"/> Occasional |
| <input type="checkbox"/> Cigarettes/Pack Per Day? _____ | <input type="checkbox"/> Daily | <input type="checkbox"/> Amphetamines | <input type="checkbox"/> 3-4x/week | <input type="checkbox"/> Daily |
| <input type="checkbox"/> Pipe | <input type="checkbox"/> Heavy | <input type="checkbox"/> Other _____ | <input type="checkbox"/> 5-7x/week | |
| <input type="checkbox"/> Cigars | | | | |
| <input type="checkbox"/> Chewing Tobacco | | | | |
| How Many Years? _____ | Have you ever been treated for alcoholism? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ | Have you ever been treated for drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ | Type: _____ | How Much: _____ |

Any religious beliefs that would affect your medical care? _____

Occupational History

Employer: _____ Job Title: _____

Have you ever altered your job as a result of the problem that brought you 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? _____

Education

(Please check highest level)

Grade School High School College Post Graduate

Immunizations

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

Other

Screenings: _____ Colonoscopy: _____