Georgetown Medical Clinic
SPECIALISTS IN FAMILY MEDICINE

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

Medication	Dose/Number per Day

Non-Prescription Medications

Medication	Dose/Number per Day

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

Date	Type of Surgery	Date	Type of Surgery

Hospitalizations

Date	Reason	Facility

Family History

Mother	□ Living □ Deceased	Age:____	Medical History or Cause of Death	□ High Blood Pressure □ Diabetes □ Cholesterol □ Cancer: Type _____ □ Other _____
Father	□ Living □ Deceased	Age:____	Medical History or Cause of Death	□ High Blood Pressure □ Diabetes □ Cholesterol □ Cancer: Type _____ □ Other _____
Brothers	# Living ___ # Deceased __	Age:____	Medical History or Cause of Death	□ High Blood Pressure □ Diabetes □ Cholesterol □ Cancer: Type _____ □ Other _____
Sisters	# Living ___ # Deceased __	Age:____	Medical History or Cause of Death	□ High Blood Pressure □ Diabetes □ Cholesterol □ Cancer: Type _____ □ Other _____

Patient Name: _____

Social History

(Please check the appropriate listings)

Tobacco Use	**Alcohol Use**	**Drug Use**	**Exercise**	**Caffeine Use**
□ Never	□ None	□ None	□ None	□ None
□ Quit/When?	□ Socially	□ Marijuana	□ 1-2x/week	□ Occasional
□ Cigarettes/Pack Per Day? _____	□ Daily	□ Amphetamines	□ 3-4x/week	□ Daily
□ Pipe	□ Heavy	□ Other _____	□ 5-7x/week	
□ Cigars				
□ Chewing Tobacco				
How Many Years? _____	Have you ever been treated for alcoholism? □ Yes □ No If yes, when? ____	Have you ever been treated for drug use? □ Yes □ 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: _____