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.)

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

☐ Cancer: Type/Treatment: ____

☐ Other (Specify): ____

Past Surgical History

(Type of Surgery & Year)

1. ____________________________________
2. ____________________________________
3. ____________________________________
4. ____________________________________
5. ____________________________________
6. ____________________________________

Prescription Medications

Medication Dose/Number per Day

1. ____________________________________
2. ____________________________________
3. ____________________________________

Medication Dose/Number per Day

4. ____________________________________
5. ____________________________________
6. ____________________________________

Non-Prescription Medications

Medication Dose/Number per Day

1. ____________________________________
2. ____________________________________
3. ____________________________________

Medication Dose/Number per Day

4. ____________________________________
5. ____________________________________
6. ____________________________________

Patient Name: ______________________________________

Drug Allergies /Type of Reaction

☐ No known drug allergies
☐ Latex
☐ Tape

1. ________________________
2. ________________________
3. ________________________
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	☐ Living ☐ Deceased	Age: _____	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type _______________ ☐ Other ___________
Mother	☐ 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: ____

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: ____________