

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	Anxiety	High Cholesterol	Allergy: Food
Heart Disease	Bleeding Difficulties	Seizure	Allergy: Seasonal
High Blood Pressure	Hepatitis A B or C	Loss of Consciousness	TB
Stroke/TIA	HIV	Arthritis (Type) _____	Hypothyroid
Obstructive Sleep Apnea	Diabetes-Diet Controlled	Asthma	Hyperthyroid
Coronary Artery Disease	Diabetes-Oral Meds	Emphysema	
Depression	Diabetes-On Insulin	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	Living Deceased	Age: _____	Medical History or Cause of Death	High Blood Pressure Cancer: Type _____	Diabetes Other _____	Cholesterol Other _____
Mother	Living Deceased	Age: _____	Medical History or Cause of Death	High Blood Pressure Cancer: Type _____	Diabetes Other _____	Cholesterol Other _____
Brothers	# Living _____ # Deceased _____	Age: _____	Medical History or Cause of Death	High Blood Pressure Cancer: Type _____	Diabetes Other _____	Cholesterol Other _____
Sisters	# Living _____ # Deceased _____	Age: _____	Medical History or Cause of Death	High Blood Pressure Cancer: Type _____	Diabetes Other _____	Cholesterol 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: _____