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	Medication	Dose/Number per Day
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

Non-Prescription Medications

Medication	Dose/Number per Day	Medication	Dose/Number per Day
1. _____		4. _____	
2. _____		5. _____	
3. _____		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	**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	Have you ever been treated for alcoholism?	Have you ever been treated for drug use?	Type: _____	How much? _____
			_____	_____
How many years? _____	Yes No	Yes No	_____	_____
	If yes, when? _____	If yes, when? _____		

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: _____