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: _____