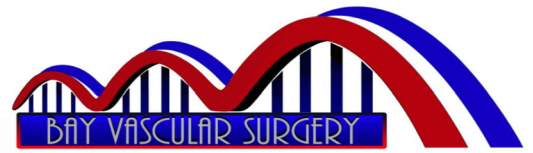


# Initial Clinical History and Physical Form



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.)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> None                    | <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Allergy: Food     |
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Bleeding Difficulties    | <input type="checkbox"/> Seizure                | <input type="checkbox"/> Allergy: Seasonal |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Hepatitis A B or C       | <input type="checkbox"/> Loss of Consciousness  | <input type="checkbox"/> TB                |
| <input type="checkbox"/> Stroke/TIA              | <input type="checkbox"/> HIV                      | <input type="checkbox"/> Arthritis (Type) _____ | <input type="checkbox"/> Hypothyroid       |
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Diabetes-Diet Controlled | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hyperthyroid      |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Diabetes-Oral Meds       | <input type="checkbox"/> Emphysema              |  |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Diabetes-On Insulin      | <input type="checkbox"/> 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	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Age: _____	Medical History or Cause of Death	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Other _____
Mother	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Age: _____	Medical History or Cause of Death	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Other _____
Brothers	# Living _____ # Deceased _____	Age: _____	Medical History or Cause of Death	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Other _____
Sisters	# Living _____ # Deceased _____	Age: _____	Medical History or Cause of Death	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> 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: \_\_\_\_\_