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 Preassure
- Stroke/TIA
- Obstructive Sleep Apnea
- Coronary Artery Disease
- Depression
- Anxiety
- Bleeding Difficulties
- Hepatitis A,B, or C
- HIV
- Deabetes-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		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.		