NEW PATIENT

INITIAL CLINICAL HISTORY AND PHYSICAL FORM

Date: _____

Name: _____ Age: _____ Date of Birth: ____/____/_____

Race: ☐ **African American** ☐ **Asian** ☐ **Caucasian** ☐ **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:

☐ 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:_____

Past Surgical History (Type of Surgery & Year)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Prescription Medications (Name and MG)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Non-Prescription Medications (Name and MG)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Drug Allergies/Type of Reaction

☐ No known Allergies ☐ Latex ☐ Tape

☐ Other

1. _____ 2. _____ 3. _____

Social History: **Patient Name:** _____
(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? ☐ Yes ☐No If yes, when? _____	Have you ever been Treated for drug use? ☐ Yes ☐No If yes, when? _____	Type: _____ _____ _____	Type: _____ _____ _____

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

For Females

Are you pregnant?_____ Are you breastfeeding? _____ # 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: _____