INITIAL CLINICAL HISTORY & PHYSICAL FORM

DATE______________________________

PATIENT INFORMATION

Name______________________________Age________Date of Birth____/____/____ Height:______

Sex: M___ F___ Race: Caucasian___Afro-American___Oriental___Indian___Other___ Weight:_____

Family Doctor:________________________Referring Doctor:______________________

Reason for Visit/Chief Complaint____

PAST SURGICAL HISTORY

Type of Surgery/Year 1.____

2.____

3.____

4.____

REVIEW OF SYSTEMS

General
Weight loss
Weight gain
Fever
Fatigue

Eyes
Pain
Discharge
Light sensitivity
Blurred vision

ENT
Sore throat
Hoarseness
Ear ringing
Nosebleeds

Respiratory
Wheezing
Cough
Shortness of breath

Cardiovascular
Chest pain
Fainting
Feet swelling
Palpitations

Gastrointestinal
Abdominal pain
Nausea
Vomiting
Diarrhea
Blood in stool

Genitourinary
Frequency
Hesitancy
Flank pain
Painful urination
Blood in urine

Neurological
Headache
Confusion
Numbness
Slurred speech
Seizures

Musculoskeletal
Joint swelling
Joint redness
Joint pain

Skin/Breast
Rash
Itching
Sores
Abscess
Discharge
Lumps

Endocrine
Excess sweat
Excess thirst
Excess hot
Excess cold

Hematologic/Lymphatic
Bleeding tendencies
Lymph node swelling
Easy bruising

Psychological
Anxiety
Depression
Severe stress

FOR FEMALES:
Are you pregnant? _______
Date of last menstrual period _________
Menstrual irregularity? Yes____ No____

IMMUNIZATIONS:
Flu: Date_________
Pneumonia Date_____
Others: Dates________

SOCIAL HISTORY

Tobacco Use
Never
Quit smoking
When?_________
Chewing tobacco
Pipe
Cigars
Cigarettes
Packs per day_____

Alcohol Use
None
Socially
Daily
Heavy

Have you been treated for alcoholism?
No___ Yes___

Drug Use
Marijuana
Cocaine
Amphetamines
Other

Have you been for drug addiction?
No___ Yes___

I currently live in
a house
an apartment
a mobile home
a retirement facility

Marital Status
Single
Married
Divorced
Widowed

Have you altered your job as a result of the problem that brought you here today? Yes___ No___
If yes,explain:____

____

If you are currently off work because of the problem, how long have you been off work?

____

FAMILY HISTORY

Heart Disease___ Diabetes___ Stroke___ Cancer___ Other______________________

Father-Living/Dec'd Age___ Cause of Death______________________ Age at Death___

Mother-Living/Dec'd Age___ Cause of Death______________________ Age at Death___

Brothers: #Alive___ # Dec'd___ Ages__________ Cause of Death__________________

Sisters: #Alive___ # Dec'd___ Ages__________ Cause of Death__________________

EMERGENCY CONTACT OR CAREGIVER

Name______________________________ Relation to Patient____________________

Daytime Phone______________________ Night Phone__________________________

Information provided by:____
Signature of Patient or Family Member Relationship Date