# Initial Clinical History and Physical Form

| Date:   |                            |                                 |                     |
|---|----------------------------|---------------------------------|---------------------|
| Patient Information   |                            |                                 |                     |
| Name:   |                            | Age: Date of Birth:             | _//                 |
| Race:   Caucasian   Afric   | can American 🗆 Asian 🗆 H   | lispanic 🗆 Multi-Racial 🗆 Other | 1000                |
| Sex: □ Male □ Female  | Marital Status:   Single [ | ☐ Married ☐ Divorced ☐ Widow    | ved # Children      |
| Previous Family Physician:  |                            | Referring Physician:            |                     |
| Reason for Visit:   |                            |                                 |                     |
| Past Medical History<br>(Please check all conditions that you has | ve or have had.)           |                                 |                     |
| □ None  | ☐ Anxiety                  | ☐ High Cholesterol              | Allergy: Food       |
| ☐ Heart Disease   | □ Bleeding Difficulties    | □ Seizure                       | □ Alliergy: Seasona |
| ☐ 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  |                            |                                 |                     |
|   |                            |                                 |                     |
| 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   | 1.25                       | 4                               |                     |
| 2   |                            | 5                               |                     |
| 3   |                            | 6                               |                     |
| Non-Prescription Medicat  | ions                       |                                 |                     |
| Medication  | Dose/Number per Day        | Medication                      | Dose/Number per Day |
| 1   |                            | 4                               |                     |
| 2   |                            | 5                               |                     |
| 3   |                            | 6                               |                     |

# **Sample History And Physical Forms**

**RJ Alexander** 

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• Interactive and Gamified eBooks

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