Initial Clinical History and Physical Form

Atlantic Health MEDICAL ASSOCIATES

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/Friend: _____

Reason for Visit: _____

Any religious beliefs that would affect your medical care? _____

Past Medical History

(Please check all conditions that you have or have had.)

☐ 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) _____	☐ Hyporthyroid
☐ Obstructive Sleep Apnea	☐ Diabetes-Diet Controlled	☐ Asthma	☐ Hyperthyroid
☐ Coronary Artery Disease	☐ Diabetes-Oral Meds	☐ Emphysema	
☐ Depression	☐ Diabetes-On Insulin	☐ Osteoporosis	

☐ Cancer: Type/Treatment: _____

☐ Other (Specify): _____

Past Surgical History (Type of Surgery & Year)

☐ No past surgery

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Prescription Medications (Medication and Dose/Number per Day)

☐ Not taking any prescription medications.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Non-Prescription Medications (Medication and Dose/Number per Day)

☐ Not taking any non-prescription medications.

1. _____
2. _____
3. _____

Drug Allergies /Type of Reaction

☐ No known drug allergies (ex. Latex, Tape)

1. _____
2. _____
3. _____

Patient Name: _____

Social History

(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?	Have you ever been treated for drug use?	Type: _____	How much? _____
How many years? _____	☐ Yes ☐ No	☐ Yes ☐ No	_____	_____
	If yes, when? _____	If yes, when? _____	_____	_____

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(s): ___	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type_____ ☐ Other _____
Sisters	☐ Living____ ☐ Deceased____	Age(s): ___	Medical History or Cause of Death	☐ High Blood Pressure ☐ Diabetes ☐ Cholesterol ☐ Cancer: Type_____ ☐ Other _____

For Females:

Are you pregnant? _____ Are you breast feeding? _____ # of Pregnancies/Deliveries: _____

Type of Birth Control_____ First menstrual period_____ Last menstrual period: _____

Last Mammogram: _____ Last Pap: _____ Last Bone Density Scan: _____

For Males:

Do you experience impotency? ☐ Yes ☐ No Erectile Problems: ☐ Yes ☐ No

Immunizations:

Flu Date: _____ Pneumonia Date: _____ Teatnus Date:_____

Other:

Screenings: _____ Colonoscopy Date: _____