Initial Clinical History Form

Patient Information **Date:** ____________________

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

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Multi-Racial ☐ Other _______________

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed # Children _____

Education (Please check highest level)

☐ Grade School ☐ High School ☐ College ☐ Post Graduate ____________________________

Occupational History

Employer: ____ Job Title: ________________________________

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) ___________	☐ 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 (Specify): ____________________________

Colonoscopy ☐ Yes ☐ No Date Performed: ____________________ Performed by: ____________________________

Past Surgical History

(Type of Surgery & Year)

1. ______________________ 3. ______________________ 5. ______________________

2. ______________________ 4. ______________________ 6. ______________________

Prescription Medications

(Medication/Dose/Number per day)

1. ______________________ 3. ______________________ 5. ______________________

2. ______________________ 4. ______________________ 6. ______________________

Non-Prescription Medications

(Medication/Dose/Number per day)

1. ______________________ 3. ______________________ 5. ______________________

2. ______________________ 4. ______________________ 6. ______________________

What is your weight? _________ **How long have you been at that weight?** _________ **What is your height?** _________

Have you taken Cortisone type drugs? ☐ **Yes** ☐ **No**
If YES, When? ______________________

Have you ever had blood products transfused? ☐ Yes ☐ No
If YES, When? ______________________

Allergies/Type of Reaction ☐ **Drug** ☐ **Food** ☐ **Latex** ☐ **Tape**

1. ______________________ **2.** ______________________ **3.** ______________________
(Medication/food)

1. ______________________ **2.** ______________________ **3.** ______________________
(Reaction)

Patient name ______________________________ Date of Birth ______________________

What is your main problem(s)? ____

____

____

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 Pap: _______________

Last Mammogram: ____________________ Last Bone Density Scan: ____________________

Have you had a hysterectomy? ☐ Yes ☐ No Date __________________ Reason______________________________

For Males:

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

Explain____

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 ☐ Cigars	☐ Heavy	☐ Other ____________	☐ 5-7/week	
☐ 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? _________	______________	______________

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 __________