Scheidler Medical Preferred, LLC - Initial Clinical History and Physical Form

Patient Name:_____ **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:**	
Reason for Visit:		

Past Medical History

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

☐ None
☐ Heart Disease
☐ High Blood Pressure
☐ Stroke/TIA
☐ Obstructive Sleep Apnea
☐ Coronary Artery Disease
☐ Depression
☐ Anxiety
☐ Bleeding Difficulties
☐ Hepatitis A B or C
☐ HIV
☐ Diabetes-Diet Controlled
☐ Diabetes-Oral Meds
☐ Diabetes-On Insulin
☐ High Cholesterol
☐ Seizure
☐ Loss of Consciousness
☐ Arthritis (Type) _____
☐ Asthma
☐ Emphysema
☐ Osteoporosis
☐ Allergy: Food
☐ Allergy: Seasonal
☐ TB
☐ Hypothyroid
☐ Hyperthyroid

☐ Cancer: Type/Treatment: _____

☐ Other (Specify): _____

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. _____		5. _____	
2. _____		6. _____	
3. _____		7. _____	
4. _____		8. _____	

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Non-Prescription Medications

Medication	Dose/Number per Day	Medication	Dose/Number per Day
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

Drug Allergies /Type of Reaction

☐ No known drug allergies 1. _____ 3. _____

☐ Latex

☐ Tape 2. _____ 4. _____

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

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? _____

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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 _____

Females

Are you pregnant? _____ Are you breast feeding? _____

# 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: _____

Males

Do you experience impotency? _____ Erectile Problems: _____

Immunizations:

Flu Date: _____ Pneumonia Date: _____ Tetanus Date: _____

Other:

Screenings: _____ Colonoscopy Date: _____ DEXA Scan: _____