CaroMont Health
CLiC Immediate Care

HISTORY AND PHYSICAL

Name _____ SS# _____ Date _____
Address _____ Occupation _____
Phone (Home) _____ (Work) _____ Date of Birth _____
Preferred Pharmacy _____Pharmacy Phone # _____

DRUG ALLERGIES

Drug	Reaction

CURRENT MEDS

Drug	Dosage

FAMILY HISTORY

	Father	Mother	Father'sP arentsss	Mother's Parents	Siblings	Children
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/convulsions	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

☐ Shortness of Breath
☐ Heart Palpitations
☐ Heart Murmur
☐ Chest Pain
☐ Dizziness/fainting
☐ Peripheral Vascular Disease
☐ Allergies/hay fever
☐ Asthma
☐ Bronchitis
☐ Pneumonia
☐ Ulcer
☐ GI Disorder

☐ Gallbladder Disease
☐ Prostate Disease
☐ Bowel Irregularity
☐ Incontinence
☐ Sexual/Menstrual Dysfunction
☐ Venereal Disease
☐ Hepatitis
☐ Anemia
☐ Arthritis
☐ Osteoporosis
☐ Depression
☐ Gout

☐ Scarlet Fever
☐ Chronic rashes
☐ Rheumatic Fever
☐ Mumps
☐ Measles
☐ Rubella
☐ Polio
☐ Diptheria
☐ Tetanus
☐ _____
☐ _____
☐ _____

HABITS

☐ Smoke: Packs Daily _____
How Long _____
☐ Interested in Stopping? _____
☐ Exercise Routine _____
_____
Contact with blood or body fluid at work:
_____

☐ Coffee: Cups Daily _____
Other Caffeine _____
☐ Alcohol: Type/Amount_____
☐ Diet: Salt intake _____
Fat intake _____
_____
_____

For Office Use Only
_____SMK
_____ HDL
_____ Age/Sex
_____ LTN
_____ DM
_____ FH