Maple Street Clinic

History & Physical

Name: _____ Date: _____
DOB: _____ Age: _____
Occupation_____
Phone: (home) _____ (cell) _____

Social History
Smoke: Yes No Packs daily _____ How Long ____ Stop smoking info given: _____
Exercise: Yes No Type _____ How Often: _____
Number of sexual partners in past year_____ Education Level _____
Sexual Orientation (optional)_____ Alcohol: Type: _____ Amount: _____
Any Concern about STD or HIV/AIDS _____ Are you afraid of anyone in your life? ___

Drug Allergies

_____

_____

_____

Current Medications

_____

_____

_____

_____

Past Medical History

Reason	Date

Surgery/ Hospitalizations

Reason	Date

Women Only Pregnant? YES NO Planning Pregnancy? YES NO LMP _____

Family History	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Mental Illness						
High Blood Pressure						
Kidney Disease						
Thyroid Disease						
Seizures/Epilepsy						

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Name: _____ **DOB:** _____ **Date:** _____

Nutrition History

1.) How many meal and snacks do you eat each day?
Meals _____ Snacks _____

2.) How many times a week do you eat the following meals away from home?
Breakfast _____ Lunch _____ Dinner _____
What types of eating places do you frequently visit? (Check all that apply)
Fast Food _____ Diner/Cafeteria_____
Restaurant _____ Other _____

3.) On average, how many pieces of fruit or glasses of juice do you eat or drink each day?
Fruit _____ Juice _____

4.) On average, how many servings of vegetables do you eat each day? _____

5.) On average, how many times a week do you eat a high fiber breakfast cereal? ___

6.) How many times a week do you eat red meat (beef, lamb, veal,) or pork? _____

7.) How many times a week do you eat chicken or turkey? _____ White or Dark

8.) How many times a week do you eat fish or shell fish? _____

9.) How many hours of television or video/computer games do you watch/play every day? _____
Do you usually snack while watching or playing television and/or video/games?
Yes _____ NO____

10.) How many times a week do you eat desserts or sweets? _____

11.) What types of beverages do you usually drink? How many servings of each do you drink a day?

Water _____
Juice_____
Soda _____
Diet Soda_____
Sports Drinks____
Iced tea _____
Iced Tea with sugar_____
Kool aid sweet _____
Kool aid sugar free _____

Milk:
Whole Milk _____
2% _____
1%_____
Skim _____
Chocolate _____

Alcohol:
Beer _____
Wine _____
Mixed Drinks _____
hard liquor_____

http://www.aafp.org/afp/990315ap/1521.htm

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Name:_____ **DOB:** _____ **Date :** _____

Medical History

Headache _____
Seizures _____
Blurred Vision _____
Dizziness/Fainting _____
Head injury _____
Asthma _____
Shortness of breath _____
Allergies/Sinusitis _____
Bronchitis _____
Pneumonia _____
TB _____
Heart Palpitations _____
Heart Murmur _____
Heart Disease _____
High Cholesterol _____
High Blood Pressure _____
Chest Pain _____
Peripheral Vascular Disease _____
Ulcer _____
GI Disorder _____
Lactose Intolerance _____
Gallbladder Disease _____
Bowel irregularity _____
Weight gain/loss recently _____
Prostate Disease _____
Incontinence _____
Frequent infections _____

Anemia _____
Arthritis _____
Back surgery/ pain _____
Osteoporosis _____
Gout _____
Depression _____
Nervousness _____
Anxiety _____
Bipolar _____
Scarlet Fever _____
Rheumatic Fever _____
Mumps _____
Measles _____
Rubella _____
Polio _____
Diphtheria _____
Tetanus _____
Last Tetanus shot _____
Blood transfusion prior to 1985 ____
Age Period Began _____
Periods Regular _____
Contraceptive Method _____
Pregnancy _____
Live Births _____
Miscarriages _____
Still Births _____
Abortions _____

Preventative History

Advanced Directive (living will) **Yes No** Durable Power of attorney for healthcare **Yes No**

Immunization History

Influenza _____ Hepatitis B _____
Tetanus _____ Pneumonia _____
TB skin test _____ Dtap _____

Health Maintenance

Cholesterol _____ Pap smear _____ PSA _____ CXR _____ Prostrate Exam _____
Breast Exam _____ Rectal Exam _____ EKG _____ A1c _____
Mammogram _____ Occult Blood _____ Dental Exam _____ Yearly Labs _____