Plano Primary Care Clinic

Initial Clinical History and Physical Form

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

Previous Family Physician: _____ Referring Physician: _____

Reason for Visit: _____

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	Tuberculosis (Tb)
Stroke / TIA	HIV	Arthritis (Type)_____	Hypothyroid
Sleep Apnea	Diabetes – Diet Controlled	Asthma	Hyperthyroid
Coronary Artery Disease	Diabetes – Oral Medication	Emphysema	
Depression	Diabetes – On Insulin	Osteoporosis	

Cancer: Type / Treatment: _____

Other (Specify): _____

Past Surgical History
(Type of Surgery and Year)

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

Prescription Medication

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

Non-Prescription Medication

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

Your Pharmacy's Name: _____ **Pharmacy Phone #:** _____