West Jefferson Medical Center
LCMC Health

# CLINIC HISTORY & PHYSICAL



*PATIENT INFORMATION*

PLACE PATIENT'S LABEL HERE

Date: ______________________ Patient Name: ______________________
Date of Birth: ______________________ Social Security #: ______________________

**Current Medications** | **Strength** | **Directions**
☐ None

**Drug Allergies**
☐ None

Exercise
Type of Exercise ________
How often done: ________

**Childhood Diseases**
☐ None
☐ Measles
☐ Mumps
☐ Rubella
☐ Other ______________
☐ Chicken Pox
☐ Rheumatic Fever
☐ Scarlet Fever

**Personal Information**
Marital Status: ______________
Occupation: ______________
Level of Education: ______________
How many dependents? ______________

**Alcohol Use**
☐ None
☐ Beer ________cans/day for ________years
☐ Wine ________drinks/day for ________years
☐ Liquor ________drinks/day for ________years
☐ Quit - Date ______________

**Family History**
☐ Father Deceased - Cause of Death: ________
☐ Mother Deceased - Cause of Death: ________

| | Father | Mother | Brother | Sisters |
|---|---|---|---|---|
| Heart Disease | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ |
| Epilepsy/Convulsions | ☐ | ☐ | ☐ | ☐ |
| Bleeding Disorder | ☐ | ☐ | ☐ | ☐ |
| Kidney Disorder | ☐ | ☐ | ☐ | ☐ |
| Thyroid Disorder | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ |

**History of Drug Use**
☐ None Please list drugs used and date stopped
______________ Quit ________
______________ Quit ________
______________ Quit ________
______________ Quit ________

**Tobacco Abuse**
☐ None
☐ Cigarettes ________packs/day for ________years ☐ Quit Date - ________
☐ Cigars ________packs/day for ________years ☐ Quit Date - ________
☐ Pipes ________packs/day for ________years ☐ Quit Date - ________
☐ Chew tobacco ________packs/day for ________years ☐ Quit Date - ________

**Abuse Assessment Questions:**
1 Are you in a situation or relationship that causes fear, pain or injury? YES NO
2 Do you need information on where to get help if you are being abused? YES NO

**Spiritual Assessment Questions:**
Do you have any spiritual beliefs that will influence your treatment at this facility? YES NO

**Fall Risk Assessment:**
1 Have you had any falls in the last 6 months? YES NO
2 Have you started any new Medications? YES NO
3 Are you experiencing any dizziness, lightheaded, or weak spells now? YES NO
4 Do you use an ambulatory aid such as a walker, cane or wheelchair? YES NO
5 Medications that increase the risk of falling? ____________

**Learning & Needs Assessment Questions:**

**Communication barriers:**
☐ Visually Imparied
☐ Speech Impaired
☐ Primary language other than English ____________
☐ Hearing Impaired
☐ Literacy Impaired

**Learns Best by:**
☐ Reading
☐ Doing
☐ Frequent Repetition
☐ Discussion
☐ Demonstration

**Signature:**
X

**Date** MM/DD/YY
/ /

**Time** 00:00 AM/PM
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*EL183*