West Jefferson Medical Center
LCMC Health

CLINIC HISTORY & PHYSICAL

PATIENT INFORMATION

PLACE PATIENT'S LABEL HERE

Date: _____BBB_____Patient Name:_____BBBBBB_____

Date of Birth:_____ Social Security #: _____

Current Medications **Strength** **Directions**

☐ None

Drug Allergies

☐ None

Exercise
Type of Exercise
_____
How often done:
_____

Childhood Diseases

☐ None ☐ Chicken Pox
☐ Measles ☐ Rheumatic Fever
☐ Mumps ☐ Scarlet Fever
☐ Rubella
☐ Other _____

Personal Information

Marital Status: _____
Occupation: _____
Level of Education: _____
How many dependents? _____

Alcohol Use

☐ None
☐ Beer _____cans/day for _____
☐ Wine _____drinks/day for _____
☐ Liquor _____drinks/day for _____
☐ Quit - Date _____

Family History

☐ Father Deceased - Cause of Death:_____
☐ Mother Deceased - Cause of Death:_____

	Father	Mother	Brother	Sisters
Heart Disease	☐	☐	☐	☐
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 _____

Tobacco Abuse

☐ None
☐ Cigarettes _____packs/day for _____years ☐ Quit Date - _____
☐ Cigars _____packs/day for _____years ☐ Quit Date - _____
☐ Pipes _____packs/day for _____years ☐ Quit Date - _____
☐ Chewing Tobacco _____packs/day for _____years ☐ Quit Date - _____

Abuse Assessment Questions:

1 Are you in a situation or relationship that causes fear, pain or ...? 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 Impaired ☐ Hearing Impaired
☐ Speech Impaired ☐ Literacy Impaired
☐ Primary language other than English _____

Learns Best by:

☐ Reading ☐ Discussion
☐ Doing ☐ Demonstration
☐ Frequent Repetition

Signature: X

Date MM/DD/YY / /

Time 00:00 AM/PM :