

## 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 # Children \_\_\_\_\_

Previous Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

### Past Medical History

(Please check all conditions that you have or have had.)

- |                                                  |                                                   |                                                 |                                            |
|--------------------------------------------------|---------------------------------------------------|-------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> None                    | <input type="checkbox"/> Anxiety                  | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Allergy: Food     |
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Bleeding Difficulties    | <input type="checkbox"/> Seizure                | <input type="checkbox"/> Allergy: Seasonal |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Hepatitis A, B or C      | <input type="checkbox"/> Loss of Consciousness  | <input type="checkbox"/> TB                |
| <input type="checkbox"/> Stroke/TIA              | <input type="checkbox"/> HIV                      | <input type="checkbox"/> Arthritis (Type) _____ | <input type="checkbox"/> Hypothyroid       |
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Diabetes-Diet Controlled | <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hyperthyroid      |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Diabetes-Oral Meds       | <input type="checkbox"/> Emphysema              |                                            |
| <input type="checkbox"/> Depression              | <input type="checkbox"/> Diabetes-On Insulin      | <input type="checkbox"/> Osteoporosis           |                                            |

☐ Cancer: Type/Treatment: \_\_\_\_\_

☐ Other (Specify): \_\_\_\_\_

### Past Surgical History

(Type of Surgery & Year)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

### Prescription Medications

Medication	Dose/Number per Day
------------	---------------------

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Medication	Dose/Number per Day
------------	---------------------

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

### Non-Prescription Medications

Medication	Dose/Number per Day
------------	---------------------

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Medication	Dose/Number per Day
------------	---------------------

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

# History And Physical Forms For Internal Medicine

**Siddappa N.Byraredddy**



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## **Table of Contents History And Physical Forms For Internal Medicine**

1. Understanding the eBook History And Physical Forms For Internal Medicine
  - The Rise of Digital Reading History And Physical Forms For Internal Medicine
  - Advantages of eBooks Over Traditional Books
2. Identifying History And Physical Forms For Internal Medicine
  - Exploring Different Genres
  - Considering Fiction vs. Non-Fiction
  - Determining Your Reading Goals
3. Choosing the Right eBook Platform
  - Popular eBook Platforms
  - Features to Look for in an History And Physical Forms For Internal Medicine
  - User-Friendly Interface
4. Exploring eBook Recommendations from History And Physical Forms For Internal Medicine

- Personalized Recommendations
- History And Physical Forms For Internal Medicine User Reviews and Ratings
- History And Physical Forms For Internal Medicine and Bestseller Lists
- 5. Accessing History And Physical Forms For Internal Medicine Free and Paid eBooks
  - History And Physical Forms For Internal Medicine Public Domain eBooks
  - History And Physical Forms For Internal Medicine eBook Subscription Services
  - History And Physical Forms For Internal Medicine Budget-Friendly Options
- 6. Navigating History And Physical Forms For Internal Medicine eBook Formats
  - ePub, PDF, MOBI, and More
  - History And Physical Forms For Internal Medicine Compatibility with Devices
  - History And Physical Forms For Internal Medicine Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of History And Physical Forms For Internal Medicine
  - Highlighting and Note-Taking History And Physical Forms For Internal Medicine
  - Interactive Elements History And Physical Forms For Internal Medicine
- 8. Staying Engaged with History And Physical Forms For Internal Medicine
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers History And Physical Forms For Internal Medicine
- 9. Balancing eBooks and Physical Books History And Physical Forms For Internal Medicine
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection History And Physical Forms For Internal Medicine
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine History And Physical Forms For Internal Medicine
  - Setting Reading Goals History And Physical Forms For Internal Medicine
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of History And Physical Forms For Internal Medicine

- Fact-Checking eBook Content of History And Physical Forms For Internal Medicine
- Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
  - Utilizing eBooks for Skill Development
  - Exploring Educational eBooks
- 14. Embracing eBook Trends
  - Integration of Multimedia Elements
  - Interactive and Gamified eBooks

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