

LEE MEDICAL, PC

HISTORY & PHYSICAL SCREENING FORM

PATIENT NAME _____ DOB: _____ AGE: _____ DATE: _____

ADDRESS: _____ PHONE: (H) _____ (W) _____ (C) _____

EMERGENCY CONTACT: _____ RELATIONSHIP _____ PHONE: _____

ALLERGIES:

CURRENT MEDICATIONS:

PHARMACY: _____ PHARMACY LOCATION: _____

PRIMARY CARE PROVIDER: _____ TELEPHONE: _____

REASON FOR VISIT: _____

PAST MEDICAL HISTORY:

DETAILS

SURGERY: YES / NO _____

HOSPITALIZATION YES / NO If yes, reason: _____

OTHER: YES / NO _____

PERSONAL HISTORY

FAMILY HISTORY

HYPERTENSION: YES / NO

HYPERTENSION: YES / NO - WHO _____

PREGNANCY: YES / NO

DIABETES: YES / NO - WHO _____

DIABETES: YES / NO

CANCER: YES / NO - WHO _____

CANCER: YES / NO

IF YES, LOCATION _____

IF YES, LOCATION _____

HEART: YES / NO - WHO _____

HEART: YES / NO

SMOKING: YES / NO

SMOKING: YES / NO - WHO _____

ALCOHOL/SUBSTANCE: YES / NO

ALCOHOL/SUBSTANCE: YES / NO - WHO _____

MENTAL ILLNESS: YES / NO

MENTAL ILLNESS: YES / NO - WHO _____

OTHER: _____

OTHER: _____