LEE MEDICAL, PC

HISTORY & PHYSICIAL SCREENING FORM

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

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

EMERGENCY CONTACT: _____ RELATIONSHIP _____ PHONE: _____

ALLERGIES: ***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: DETAILS

HYPERTENSION:	YES / NO	WHO: _____
PREGNANCY:	YES / NO	WHO: _____
CANCER:	YES / NO	WHO: _____ LOCATION: _____
DIABETES:	YES / NO	WHO: _____
HEART:	YES / NO	WHO: _____
SMOKING:	YES / NO	WHO: _____
ALCOHOL/SUBSTANCE:	YES / NO	WHO: _____
MENTAL ILLNESS:	YES / NO	WHO: _____
OTHER:	YES / NO	WHO: _____

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