

**PRIMARY CARE CLINICAL HISTORY FORM**

**PLEASE PRINT**

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender:  Male  Female  Other

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: : (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Address: \_\_\_\_\_

**Chief Complaint and Present Illness**

**Reason for visit today:**  Arthritis  Asthma  Diabetes  Cold  HTN  
 Physical  School Physical  Check Up  Follow UP

other \_\_\_\_\_

**How Long Have You Had This Illness(if applicable):** \_\_\_\_\_

**Please describe any symptoms that you are having at this time:**  
\_\_\_\_\_

**Pharmacy name, phone #, or location:**  
\_\_\_\_\_

**Medications** - List all medications you are currently taking. Include **ALL** medications even the Over The Counter ones.

Drug Name (Generic/Brand)	Dosage	Frequency

**PLEASE USE BACK OF THIS PAGE IF MORE SPACE NEEDED:**

**Medications that have caused an allergic reaction:**  
\_\_\_\_\_

**List any major illness that your immediate family members have had:**  
\_\_\_\_\_

**Have you ever had major surgery or been hospitalized? If yes, please explain:**  
\_\_\_\_\_