MEDICAL HISTORY AND PHYSICAL EXAMINATION

(TO BE COMPLETED BY YOUR PHYSICIAN)

Dear Patient - It is important that you provide us with your medical information in order to receive quality integrated treatment. Please have your primary care physician complete this form. This form can be completed online or by hand – please print this form out or contact us at TheClinic@karenhorneyclinic.org if you would like a copy mailed to you with a self-addressed stamped envelope.

If you are not having your physician complete your medical history and physical examination information at this time please check and sign below.

□ I will not complete my medical history and physical examination information at this time:

_____ _____

NAME OF PATIENT **DATE**

Physicians can complete your medical history and physical examination information by filling out the below form online or printing out and returning this form to: Attn: Dr. Henry Paul, Karen Horney Clinic, 329 E. 62nd Street, New York, NY 10065. Fax: 212-838-7158; Email: TheClinic@karenhorneyclinic.org.

PATIENT'S NAME _____ DATE _____

HOME ADDRESS_____ APT.# _____

CITY_____ STATE _____ ZIP CODE_____

HOME PHONE # _____ WORK PHONE # _____

SEX_____ GENDER:_____ D.O.B. _____ AGE _____

HEIGHT _____ WEIGHT _____ B.P. _____ TEMP.: _____

STATUS OF CURRENT HEALTH: _____

_____

_____

***A) CURRENT ILLNESSES*: _____**

***B) CHRONIC CONDITIONS*:**

_____

PAST HEALTH: _____

_____

_____

***A) SIGNIFICANT ILLNESSES*: _____**

***B) HOSPITALIZATIONS*: _____**

***C) ACCIDENTS:* _____**

SIGNIFICANT FAMILY ILLNESSES: *(If NONE, state so)* _____

_____

_____

CURRENT MEDICATIONS: *(Including Dosage, If NONE, state so)*

_____

_____

_____

PAST HISTORY *(Neonatal History. List unusual findings such as cyanosis, jaundice, birth anomaly, infections, Rh factor, asphyxia, instrument delivery, prolonged labor, hemorrhage)*

_____

_____

_____

_____

ILLNESSES *(List age of onset. If any sequela, please list under comments)*

Pertussis_____	**Polio _____**	**Seizures _____**
Measles _____	**Eczema _____**	**Mumps _____**
Scarlet Fever _____	**Diphtheria _____**	**Colitis _____**
Rheumatic Fever _____	**Chicken Pox _____**	**Asthma _____**
Injuries _____	**Operations _____**	**Hospitalizations_____**
Enuresis _____	**Allergies _____**	**Blood Dyscrasia _____**
C.N.S. Infection, Diabetes _____		**Involuntary Movements _____**

COMMENTS *(Include any other illnesses)*

_____

_____

_____

_____

GENERAL IMPRESSION (*Such as state of nutrition, obvious weight loss, chronically ill child, etc.)*

_____

_____

_____

HEAD AND NECK _____ **EYES** _____

EARS, NOSE & THROAT _____

HEART & LUNGS _____

THORAX & ABDOMEN _____

EXTREMITIES & JOINTS _____

SKIN _____ **ABNORMAL MOVEMENTS** _____

A.J. _____ **K.J.** _____ **T.J.** _____ **PLANTAR** _____

REFLEXES: ***RIGHT*** _____ ***LEFT*** _____

ARE ANY OTHER TESTS, SUCH AS LABORATORY OR X-RAY WORKUPS, REQUIRED

_____

ADDITIONAL COMMENTS _____

_____

_____

_____

_____

DIAGNOSIS_____

_____

_____

_____

COVID VACCINATION STATUS: FULLY VACCINATED_____ PARTIALLY VACCINATED_____
NOT VACCINATED_____

NAME OF EXAMINING PHYSICIAN _____

ADDRESS _____

TELEPHONE # _____

_____

SIGNATURE OF PHYSICIAN