Family
URGENT CARE
&
Industrial Medical Clinic
A Professional Corporation

MEDICAL HISTORY

PATIENT NAME:_____ **DATE:**_____

AGE:_____ How would you rate your general health?___excellent___good____fair___poor

PRESENT HEALTH CONCERNS:_____
_____
_____

CURRENT MEDICATIONS: (Medicines [Include prescription and over the counter], Vitamins,Home Remedies,Birth Control Pills, Herbs):_____
_____

ALLERGIES/REACTIONS TO MEDICATIONS:_____
_____

PAST MEDICAL HISTORY: Indicate whether you have/had any of the medical problems listed below;

_____High blood pressure	_____Stroke	_____Alcoholism
_____High cholesterol	_____Thyroid problem	_____Depression/suicide
_____ Diabetes	_____Heart disease/heart attack	_____Bleeding/clotting problems

Cancer (specify):_____
Blood transfusion (with dates):_____
Other problems (specify):_____
Surgeries/ Hospitalizations (with dates):_____
_____

Do you exercise regularly? ___No ___Yes What kind of exercise?_____

How long (minutes)?_____ How often?_____

How would you rate your diet? ___excellent ___good ___fair __poor Are you satisfied with your weight?_____

Coffee/Tea: cups/day____ Soda: cans or bottles/day_____

Do you drink alcohol? _____No _____Yes Number of drink(s)/day/week/month_____

Is your alcohol use a concern for you/others?_____

Do/did you use tobacco? ___No ___Yes cigarettes/day_____ For how long?_____

If you did use tobacco when did you quit?_____

Do/did you use any recreational drugs? ____No____Yes: _____

Your sexual partner(s) is: _____male _____female ____none Current method of birth control:_____

Have you ever had any STD's (Sexually Transmitted Diseases)?____No ____Yes:_____

Are you interested in being screened for STD's today? _____No ____Yes
(rev.3.02)

PREVENTATIVE CARE: When was your most recent:

Tetanus booster_____ Flu shot_____ Dental checkup_____
Hepatitis B vaccine__/__/__ Chicken pox/Varicella_____ Sigmoidoscopy_____
TB skin test (PPD)_____ Pneumonia vaccine_____ Exam by Eye Doctor_____
Cholesterol test_____ Stool test for blood_____
HIV/AIDS test_____

WOMAN'S HEALTH HISTORY: First day of most recent menstrual period:_____
Do you have any concerns about your periods? _____No _____Yes:_____
Age at fist period:_____ Frequency of periods:_____ Duration of periods:_____
Total # of pregnancies:_____ Number of deliveries:_____ Miscarriages:_____ Abortions:_____
Date of last Pap smear:_____ History of abnormal Pap smear? ___No ___Yes:_____
Date of last mammogram:_____ History of abnormal mammogram? ___No ___Yes:_____

FAMILY HISTORY: Is there any family history of the following ? (please indicate who had the condition)

Alcoholism_____ Heart disease _____ Stroke_____
Bleeding/clotting problems_____ Diabetes_____ Thyroid problem_____
High blood pressure_____ High cholesterol_____
Depression/suicide_____ Heart attacks_____
Cancer: skin _____ breast _____colon _____prostate _____ovary _____lungs_____
Other (specify): _____

	Living?	Age now/or at death	Major illnesses/cause of death
Mother:	_____	_____	_____
Father:	_____	_____	_____
Sister(s):	_____	_____	_____
Brother(s):	_____	_____	_____
Children:	_____	_____	_____

SOCIAL HISTORY: Birthplace:_____ Education:_____ Occupation:_____
Marital status:_____ Who lives at home with you?_____

REVIEW OF SYMPTOMS:

Constitutional
___Fevers/chills/sweats
___Unexplained weight loss/gain
___Change in energy/weakness
___Excessive thirst or urination
Breast/Chest
___Breast lump/nipple discharge
Ears/Nose/Throat
___Difficulty hearing/ringing in ears
___Problems with teeth/gums
___Hay fever
Respiratory
___Cough/wheeze/shortness of breath
Gastrointestinal
___Abdominal pain
___Nausea/vomiting/diarrhea
___Blood in bowel movement

Cardiovascular
___Chest pain/discomfort
___Murmur
___Palpitations
Genitourinary
___Painful urination
___Discharge: penis or vagina
___Unusual vaginal bleeding
Neurological
___Dizziness/light-headed
___Numbness
___Headaches
Muscular/Skeletal
___Muscle/joint pain
___Loss of coordination

Eyes
___Change in vision
Skin
___Rash
___Change in mole
Psychiatric
___Anxiety
___Depression
Blood
___Easy bruising/bleeding
Other (explain)
_____
_____
_____
_____
_____

_____ _____ _____
Name (please print) Signature Date
(rev.3.02)