

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:

- | | | |
|-------------------------------|--------------------------------------|--------------------------------------|
| <u> </u> High blood pressure | <u> </u> Stroke | <u> </u> Alcoholism |
| <u> </u> High cholesterol | <u> </u> Thyroid problem | <u> </u> Depression/suicide |
| <u> </u> Diabetes | <u> </u> Heart disease/heart attack | <u> </u> 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? _____

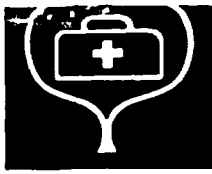
Do/did you use any recreational drugs? No Yes: _____

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

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Family
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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 first 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:

<u>Constitutional</u>	<u>Cardiovascular</u>	<u>Eyes</u>
___ Fevers/chills/sweats	___ Chest pain/discomfort	___ Change in vision
___ Unexplained weight loss/gain	___ Murmur	<u>Skin</u>
___ Change in energy/weakness	___ Palpitations	___ Rash
___ Excessive thirst or urination	<u>Genitourinary</u>	___ Change in mole
<u>Breast/Chest</u>	___ Painful urination	<u>Psychiatric</u>
___ Breast lump/nipple discharge	___ Discharge: penis or vagina	___ Anxiety
<u>Ears/Nose/Throat</u>	___ Unusual vaginal bleeding	___ Depression
___ Difficulty hearing/ringing in ears	<u>Neurological</u>	<u>Blood</u>
___ Problems with teeth/gums	___ Dizziness/light-headed	___ Easy bruising/bleeding
___ Hay fever	___ Numbness	<u>Other (explain)</u>
<u>Respiratory</u>	___ Headaches	_____
___ Cough/wheeze/shortness of breath	<u>Muscular/Skeletal</u>	_____
<u>Gastrointestinal</u>	___ Muscle/joint pain	_____
___ Abdominal pain	___ Loss of coordination	_____
___ Nausea/vomiting/diarrhea		_____
___ Blood in bowel movement		_____

 Name (please print) Signature Date
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