

# Garrisonville Urgent Care Medical History

Today's Date \_\_\_\_\_

<b>Name</b> _____ Address _____ _____ Occupation _____	Age _____ Birth Date _____ Sex <input type="checkbox"/> Male <input type="checkbox"/> Female Home Phone _____ Work Phone _____ Emergency Contact _____ Phone _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
If married, spouse's name _____	
Children's names and ages _____	

<b>Allergies to Medications, X-Ray Dyes, or Other Substances</b>	<input type="checkbox"/> No	<input type="checkbox"/> Yes
(If yes, please list name of medicine and type of reaction)		
_____	_____	_____
_____	_____	_____
_____	_____	_____

<b>Past Medical History and Review of Systems</b>			
Please check off if you have had any problems with or are presently experiencing any of the following:			
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Unexplained weight gain/loss	<input type="checkbox"/> Low back problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Skin diseases
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> T.B.	<input type="checkbox"/> Gall Bladder disease	<input type="checkbox"/> Blood disorders
<input type="checkbox"/> Chest pain/chest tightness	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Colitis	<input type="checkbox"/> Venereal diseases or STDS
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Abdominal discomfort	<input type="checkbox"/> Hepatitis or jaundice	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Indigestion	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Nausea	<input type="checkbox"/> Head or neck radiation	<input type="checkbox"/> Anemia
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Headache	<input type="checkbox"/> Alcohol abuse
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Constipation	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Gout
<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Impotence or Erectile Dysfunction
<input type="checkbox"/> History of blood transfusion	<input type="checkbox"/> Ulcers		<input type="checkbox"/> Other
_____			
_____			
_____			
_____			
_____			

<b>Gynecologic and Obstetric History</b>			
Age at onset of periods _____	Frequency _____	Length of period _____	
Pregnancies _____	Births _____	Miscarriages _____	
Prolonged or abnormal bleeding	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please describe) _____		
Leakage of urine	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please describe) _____		
Pelvic pain	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please describe) _____		
Abnormal discharge	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please describe) _____		
History of abnormal Pap smear	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please describe) _____		

This information is for use by your physician as part of your confidential medical record.

# Garrisonville Urgent Care Medical History

Name \_\_\_\_\_

## Please List and Supply the Dates of:

Operations \_\_\_\_\_

\_\_\_\_\_

Hospitalizations other than surgery \_\_\_\_\_

\_\_\_\_\_

**Immunization history**-have you had: Pneumovax immunization?  No  Yes When? \_\_\_\_\_

Hepatitis B?  No  Yes When? \_\_\_\_\_ Flu immunization?  No  Yes When? \_\_\_\_\_

Other?  No  Yes When? \_\_\_\_\_ Tetanus immunization?  No  Yes When? \_\_\_\_\_

### When was your last:

Pap Smear? \_\_\_\_\_ Breast Exam? \_\_\_\_\_ Mammogram? \_\_\_\_\_ Thyroid Check? \_\_\_\_\_

Stool check for blood? \_\_\_\_\_ Testicular Exam? \_\_\_\_\_ Sigmoidoscopy/Colonoscopy? \_\_\_\_\_

Cholesterol check? \_\_\_\_\_ Prostate exam? \_\_\_\_\_ PSA? \_\_\_\_\_ Eye Exam? \_\_\_\_\_

Dental Check-up? \_\_\_\_\_ Skin Cancer Screen? \_\_\_\_\_ Urine Analysis? \_\_\_\_\_

## Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease or unexplained sudden death	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression, etc.)	_____	_____
Drug or alcohol addition	_____	_____
Glaucoma	_____	_____
Bleeding diseases or blood clots	_____	_____
Other	_____	_____

## Current Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

## Prevention

Do you wear seat belts?  Yes  No If no, why not? \_\_\_\_\_

Do you wear a bike helmet?  Yes  No  N/A

Do you exercise regularly?  Yes  No If yes, type, duration and number of times per week? \_\_\_\_\_

\_\_\_\_\_

Do you smoke?  Yes  No If yes, how many packs per day? \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No If yes, how much per week? \_\_\_\_\_

Do you drink coffee or tea?  Yes  No If yes, how many cups per day? \_\_\_\_\_

If there is a gun in your home, do you keep it  Yes  No  N/A

unloaded and out of children's reach?

Do you use drugs? (marijuana, cocaine, crack, etc.)  Yes  No If yes, explain: \_\_\_\_\_

Have you ever engaged in any activity which has  Yes  No If yes, explain: \_\_\_\_\_

put you at risk of getting AIDS?

Do you wish to be tested for AIDS?  Yes  No

Have you ever worked with chemicals, paints,  Yes  No If yes, explain: \_\_\_\_\_

asbestos, or other hazardous materials?

Are you in a relationship in which you have been  Yes  No

physically hurt (e.g., slapped, kicked, punched,   
bruised) by your partner?

Do you have a "living will"?  Yes  No

Do you have a donor card?  Yes  No

Method of birth control? \_\_\_\_\_

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