

Pine Ridge Urgent Care & Occupational Medicine Center

Patient Health History

GENERAL INFORMATION:

Name: _____ Date of Birth: ___/___/____. Today's Date: ___/___/___.

Occupation: _____ Hobbies: _____

Sex: Male Female Marital Status: Married Divorced Separated Single Widow

Please list the people you live with

	Name	Date Of Birth	Relationship to You
1.	_____	___/___/___	_____
2.	_____	___/___/___	_____
3.	_____	___/___/___	_____
4.	_____	___/___/___	_____
5.	_____	___/___/___	_____

Past Medical History: Have you ever had?

Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle Cell Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sexually Transmitted Diseases	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No
Migraine Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	AIDS or HIV+	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infectious Mono	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Bleeding tendency blood or plasma transfusion		<input type="checkbox"/> Yes <input type="checkbox"/> No	Any other disease (please list)		
Last Menstrual Period ___/___/___		Last Tetanus Shot ___/___/___		Date of the last chest X-Ray ___/___/___	

Please List Any Past Surgery:

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

For Women/What Kind of birth control are you using?

None, don't need Diaphragm Contraceptive (Cream or Jelly) Norplant Tubes Tied Condoms
 None, but would like to discuss Partner had vasectomy Birth Control Pill/name Other _____

Patient Social History

Use of alcohol Never Rarely Moderate daily Use of drugs Never Type/Frequency _____
 Use of tobacco Never Previously, but quit Current Packs/day
 Excessive exposure at home or work to: Fumes Dust Solvents Air-borne Particles Noises
 Regular strenuous exercise outside your job: 3 Times a Week 1-2 Times a Week Rarely or Never

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling's	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

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Patient Health History

Review of Systems: Please indicate any personal history below.

Constitutional Symptoms	Yes	No
Good general Health lately	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>

Integumentary (skin, breast)	Yes	No
Rash or itching	<input type="checkbox"/>	<input type="checkbox"/>
Change in skin color	<input type="checkbox"/>	<input type="checkbox"/>
Change in hair or nails	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
Breast pain	<input type="checkbox"/>	<input type="checkbox"/>
Breast lump	<input type="checkbox"/>	<input type="checkbox"/>
Breast discharge	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal	Yes	No
Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowel movements		
Nausea or vomiting		
Frequent diarrhea		
Painful bowel movements or constipation		
Rectal bleeding or blood in stool		
Abdominal pain		

Genitourinary	Yes	No
Frequent urination		
Burning or painful urination		
Blood in urine		
Change in force of strain		
When urinating		
Incontinence or dribbling		
Kidney stones		
Sexual difficulty		
Male testicle pain		
Female pain with periods		
Female irregular periods		
Female vaginal discharge		
Female # of pregnancies	_____	
Female # of miscarriages	_____	
Female date of last pap smear	_____	
Female last mammogram	_____	

Respiratory	Yes	No
Persistent cough or throat clearing		
Not associated WITH a known illness		
(Lasting more than 3 weeks?)		
Spitting up blood		
Shortness of breath		
Wheezing		

Endocrine	Yes	No
Glandular or hormone problem		
Excessive thirst or urination		
Heat or cold intolerance		
Skin Becoming drier		
Change in hat or glove size		

Hematologic/Lymphatic	Yes	No
Slow to heal after cuts		
Bleeding or bruising tendency		
Anemia		
Phlebitis		
Past transfusion		
Enlarged glands		

Ears/Nose/Mouth/Throat	Yes	No
Hearing loss or ringing		
Earaches or drainage		
Chronics sinus problem or rhinitis		
Nose bleeds		
Mouth sores		
Bleeding gums		
Bad breath or bad taste		
Sore throat or voice change		
Swollen glands in neck		

Eyes	Yes	No
Eye disease or injury		
Wear glasses/contact lenses		
Blurred or double vision		
Other		

Musculoskeletal	Yes	No
Joint pain		
Joint stiffness or swelling		
Weakness of muscles or joints		
Muscle pain or cramps		
Back pain		
Cold extremities		
Difficulty in walking		

Neurological	Yes	No
Frequent or recurring headache		
Light headed or dizzy		
Convulsions or seizures		
Numbness or tingling sensations		
Tremors		
Paralysis		
Head injury		

Psychiatric	Yes	No
Memory loss or confusion		
Nervousness		
Depression		
Insomnia		
Suicidal Thoughts		
Violent or Unusual Thoughts		

Cardiovascular	Yes	No
Heart trouble		
Chest pain or angina pectoris		
Palpitation		
Shortness of breath w/walking or lying flat		
Swelling of feet, ankles or hands		

Allergic/Immunologic	Yes	No
History of skin reaction or		
Other adverse reaction to:		
Penicillin or other antibiotics		
Morphine, Demerol		
or other narcotics		
Novocain or other anesthetics		
Aspirin or other pain remedies		
Tetanus antitoxin		
Or other serums		
Iodine, Merthiolate or		
other antiseptic		
Other drugs/medications		

Other	Yes	No

Other: Is there anything else you would like us to know about you and your health?

Signature of Parents or Guardian

Date