Urgent Care Patients

2018 Health History

Name ____ Time: ________________

Today's Date ____ / ____ / 2018 Date of Birth ____ / ____ / _______ Gender *(Circle One)* M F

Allergies

Are you allergic to any medications or other substances?

❒ *No* ❒ *Yes (If yes, please list below)*

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Medications

Please list current medications including prescription, non-prescription, vitamins, allergy shots, etc. **or** ❒ **Please see attached list.**

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Medical Treatments, Hospitalizations, Surgeries, etc.

Please list any times/ reasons you have been in the hospital and date. Please include surgeries (inpatient and outpatient) and pregnancies.

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Past/Current Illnesses & Conditions

Please check all that apply (if any)...

- ❒ add/adhd
- ❒ alcohol dependence
- ❒ anemia/blood transfusion(s)
- ❒ anxiety/depression
- ❒ asthma
- ❒ anxiety
- ❒ arthritis
- ❒ cancer (type) ______________________
- ❒ diabetes
- ❒ emphysema or lung disease
- ❒ epilepsy/seizures/convulsions
- ❒ glaucoma
- ❒ hepatitis
- ❒ heart disease or problem
- ❒ hyper or hypothyroidism
- ❒ hypertension (high blood pressure)
- ❒ hyperlipidemia (cholesterol)
- ❒ kidney stones or disease
- ❒ leukemia
- ❒ pneumonia
- ❒ rheumatic fever
- ❒ sexually transmitted disease(s)
- ❒ stroke
- ❒ substance abuse
- ❒ tuberculosis
- ❒ ulcer(s)
- ❒ Other ___________________

Smoked Tobacco Use

- ❒ Current, every day
- ❒ Current, some days
- ❒ Former
- ❒ Never

Alcohol Use

- ❒ Yes
- ❒ No

___ drinks per day

or ❒ drink socially

Recreational Drug Use

- ❒ No
- ❒ Current
- ❒ Past

Regular Exercise

- ❒ Yes
- ❒ No

______ times per week

Type _____________

Seat Belt Use

- ❒ Always
- ❒ Never
- ❒ Intermittently

Screening/Immunizations

If applicable, please indicate the date last done... tetanus shot______________

Family History

Please list details below or check here... ❒ **I am adopted and/or have no knowledge of biological family history.**

Mother

Age (if living) ___________

Age (at death) ___________

State of health or cause of death

- ❒ Diabetes
- ❒ Heart Disease
- ❒ Hypertension/High Blood Pressure
- ❒ Other ________________________

Father

Age (if living) ___________

Age (at death) ___________

State of health or cause of death

- ❒ Diabetes
- ❒ Heart Disease
- ❒ Hypertension/High Blood Pressure
- ❒ Other ________________________

Siblings

Age(s) (if living) ___________________

Age(s) (at death) ___________________

State of health or cause of death

- ❒ Diabetes
- ❒ Heart Disease
- ❒ Hypertension/High Blood Pressure
- ❒ Other ________________________

Arrowood MEDICAL CENTER **Occumed** AT RIVERVIEW **Riverview** MEDICAL CENTER

Review of Systems

Date ________________

Name ____

Signature ____

Date of Birth ____ / ____ / _______ Gender *(Circle One)* M F

Reason for Today's Visit

____

____

____

____

Females Only:

Date of Last Menstrual Period

________________ or ❒ n/a

Pregnant ❒ yes ❒ no

Breastfeeding ❒ yes ❒ no

Menopause ❒ yes ❒ no

Review of Body Systems

Please check all symptoms or conditions that you are experiencing

TODAY ONLY...

General

- ❒ fever
- ❒ chills
- ❒ sweats/night sweats
- ❒ anorexia
- ❒ fatigue
- ❒ malaise
- ❒ weight loss
- ❒ daytime drowsiness
- ❒ difficulty sleeping/sleep changes

Eyes

- ❒ blurred vision
- ❒ double vision
- ❒ irritation
- ❒ discharge
- ❒ vision loss
- ❒ eye pain or injury
- ❒ light sensitivity
- ❒ cataracts
- ❒ glaucoma
- ❒ wear glasses or contacts

Ears, Nose, Mouth & Throat

- ❒ earache/ ear pain
- ❒ ear discharge
- ❒ ringing/buzzing in ears (tinnitus)
- ❒ decreased hearing
- ❒ nasal congestion/discharge
- ❒ nosebleeds/epistaxis
- ❒ sore throat
- ❒ hoarseness/voice change
- ❒ difficulty swallowing
- ❒ seasonal allergies
- ❒ dizziness or vertigo

Cardiovascular

- ❒ chest pain, pressure or tightness
- ❒ irregular heartbeat/palpitations
- ❒ racing heart
- ❒ blackouts/syncope
- ❒ shortness of breath
- ❒ swelling in extremeties (edema)
- ❒ history of abnormal EKG
- ❒ history of heart murmur
- ❒ history of abnormal stress test
- ❒ history of high blood pressure (hypertension)
- ❒ history of rheumatic fever
- ❒ history of valve disease

Respiratory

- ❒ cough
- ❒ shortness of breath
- ❒ excessive sputum
- ❒ coughing up blood
- ❒ wheezing
- ❒ chronic bronchitis
- ❒ history of asthma
- ❒ history of pneumonia
- ❒ history of tuberculosis

Gastrointestinal

- ❒ nausea
- ❒ vomiting
- ❒ diarrhea
- ❒ constipation
- ❒ change in bowel habits
- ❒ abdominal/stomach pain
- ❒ black stools (melena)
- ❒ blood in stool
- ❒ rectal bleeding
- ❒ yellowing of skin (jaundice)
- ❒ difficulty swallowing
- ❒ food intolerance
- ❒ heartburn/indigestion/reflux
- ❒ hemorrhoids/rectal disease
- ❒ liver trouble or disease

Genitourinary - Female

- ❒ vaginal discharge
- ❒ involuntary loss of urine/ incontinence
- ❒ painful urination
- ❒ blood in urine
- ❒ no menstruation
- ❒ heavy menstrual bleeding
- ❒ abnormal vaginal bleeding
- ❒ severe menstrual pain
- ❒ pelvic pain
- ❒ history of kidney stones

Genitourinary - Male

- ❒ painful or difficult urination
- ❒ blood in urine
- ❒ discharge
- ❒ involuntary loss of urine/ incontinence
- ❒ frequent urination
- ❒ decreased sexual desire/libido
- ❒ history of kidney stones

Musculoskeletal

- ❒ back pain or injury
- ❒ joint pain
- ❒ muscle pain
- ❒ joint swelling
- ❒ neck injury or pain
- ❒ muscle cramps
- ❒ muscle weakness
- ❒ stiffness
- ❒ arthritis
- ❒ decreased range of motion
- ❒ wasting (losing muscle mass)
- ❒ history of fracture(s)

Skin

- ❒ rash
- ❒ itching
- ❒ dryness
- ❒ suspicious lesions
- ❒ change in color or size of moles
- ❒ tumor(s) or cyst(s)
- ❒ history of skin cancer
- ❒ history of severe sunburn

Neurological

- ❒ loss of strength/paralysis
- ❒ weakness
- ❒ skin tingling, prickling, burning or numbness
- ❒ seizures
- ❒ blackouts (syncope)
- ❒ tremors/convulsions/seizures
- ❒ dizziness or vertigo
- ❒ loss of balance
- ❒ loss of sensation
- ❒ fainting
- ❒ double vision
- ❒ headache

Reviewed by

____

(Provider's Signature)

Date ______________

Psychiatric

- ❒ depression
- ❒ anxiety
- ❒ memory loss
- ❒ mental disturbance
- ❒ suicidal attempts/thoughts
- ❒ hallucinations
- ❒ paranoia
- ❒ insomnia (difficulty sleeping)
- ❒ panic symptoms
- ❒ have seen psychiatrist/ psychologist/counselor
- ❒ prior psych hospitalizations

Endocrine

- ❒ intolerance to cold
- ❒ intolerance to heat
- ❒ increased thrist
- ❒ excessive thrist
- ❒ frequent urination
- ❒ weight change
- ❒ changes in hair
- ❒ changes in skin
- ❒ fatigue
- ❒ weakness

Hematologic/Lymphatic

- ❒ abnormal bruising
- ❒ bleeding
- ❒ swollen/enlarged lymph nodes
- ❒ history of anemia

Allergic/Immunologic

- ❒ hives (urticaria)
- ❒ hay fever/seasonal allergies
- ❒ persistent infections
- ❒ itchy eyes
- ❒ stuffy nose (rhinitis)