SHAKER URGENT CARE AND FAMILY PRACTICE

Medical History

Patient Name _____ Date of Birth _____

Reason for Visit Today _____

Pharmacy 1) _____ 2) _____

Past Medical History (Please check if you have had any of the following)

High Blood Pressure ❑ **yes** ❑ **no** If yes, year of diagnosis _____

High Cholesterol ❑ **yes** ❑ **no** If yes, year of diagnosis _____

Diabetes ❑ **yes** ❑ **no** If yes, year of diagnosis _____

Bone Density Test ❑ **yes** ❑ **no** If yes, year of test _____ ❑ **normal** ❑ **abnormal**

Colonoscopy ❑ **yes** ❑ **no** If yes, year of test _____ ❑ **normal** ❑ **abnormal**

Heart Stress Test ❑ **yes** ❑ **no** If yes, year of test _____ ❑ **normal** ❑ **abnormal**

Heart Catheterization ❑ **yes** ❑ **no** If yes, year of test _____ ❑ **normal** ❑ **abnormal**

FOR MALE PATIENTS ONLY

PSA Test ❑ **yes** ❑ **no** If yes, year of test _____ ❑ **normal** ❑ **abnormal**

FOR FEMALE PATIENTS ONLY

Mammogram ❑ **yes** ❑ **no** If yes, year of test _____ ❑ **normal** ❑ **abnormal**

Pap smear ❑ **yes** ❑ **no** If yes, year of test _____ ❑ **normal** ❑ **abnormal**

Colposcopy ❑ **yes** ❑ **no** If yes, year of test _____ ❑ **normal** ❑ **abnormal**

Number of pregnancies _____ Number of births _____

Date of last menstrual period _____ Method of birth control _____

Please list any other medical conditions:

_____

_____

_____

_____

_____

Past Surgical History

Surgery	Date	Surgery	Date
1.		4.	
2.		5.	
3.		6.	

continued

Medical History *page 2*

Patient Name _____

Family History (Check in the appropriate boxes to identify all illnesses/conditions in your blood relatives)

Relative	Heart Attack	High Blood Pressure	Stroke	Colon Cancer	Breast Cancer	Colon Polyps	Prostate Cancer	Other Illness or Condition	Age if living	Age of death
Father	❑	❑	❑	❑	❑	❑	❑	❑		
Paternal Grandfather	❑	❑	❑	❑	❑	❑	❑	❑		
Paternal Grandmother	❑	❑	❑	❑	❑	❑	❑	❑		
Mother	❑	❑	❑	❑	❑	❑	❑	❑		
Maternal Grandfather	❑	❑	❑	❑	❑	❑	❑	❑		
Maternal Grandmother	❑	❑	❑	❑	❑	❑	❑	❑		
Brother	❑	❑	❑	❑	❑	❑	❑	❑		
Sister	❑	❑	❑	❑	❑	❑	❑	❑		

Social History

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Occupation _____

Exercise Type? _____ How long? _____ minutes How often? _____ times per week

	Current Use	Past Use	How often per week	How much per day
Smoking				
Caffeine				
Alcohol				
Drug Use				

Allergies (Please list all allergies)

Reaction: Date:

1

2.

3.

4.

Current Medications

Medication	Reason for taking	Dosage	Times per day	Date Started

continued

 Patient Name _____

Immunizations

Tetanus	❑ **yes** ❑ **no**	Date vaccinated _____	Gardasil Series (HPV)	❑ **yes** ❑ **no**	Date vaccinated _____
Influenza	❑ **yes** ❑ **no**	Date vaccinated _____	Zoster Vaccine	❑ **yes** ❑ **no**	Date vaccinated _____
Pneumococcal	❑ **yes** ❑ **no**	Date vaccinated _____	Varicella	❑ **yes** ❑ **no**	Date vaccinated _____
Hepatitis A Series	❑ **yes** ❑ **no**	Date vaccinated _____	Have you had		_____
Hepatitis B Series	❑ **yes** ❑ **no**	Date vaccinated _____	chicken pox?	❑ **yes** ❑ **no**	Date vaccinated _____

Review of Systems

Please check any of the following that you have experienced **in the last 3 weeks**.

Constitutional

❑ Changes in appetite ❑ Fever ❑ Recent weight gain (___lbs) ❑ Fatigue
❑ Night sweats ❑ Chills ❑ Recent weight loss (___lbs)

Skin/Integumentary

❑ Change in a wart or mole ❑ Rash ❑ Sores that won't heal

Eyes

❑ Recent changes in vision ❑ Double vision ❑ Eye pain

Ear, Nose and Throat (ENT)

❑ Loss of hearing ❑ Nasal congestion ❑ Trouble swallowing ❑ Ringing in the ears
❑ Seasonal allergies ❑ Snoring ❑ Cold symptoms ❑ Sore throat

Respiratory

❑ Wheezing ❑ Cough

Cardiovascular

❑ Fainting ❑ Calf cramps ❑ Difficulty breathing on exertion ❑ Chest pain
❑ Heart rate is fast ❑ Varicose veins ❑ Irregular heart beat ❑ Swelling of extremities

Gastrointestinal

❑ Black, tarry stool ❑ Constipation ❑ Indigestion ❑ Bloody stools
❑ Heartburn ❑ Vomiting

Genitourinary

❑ Blood in urine ❑ Painful intercourse ❑ Urinating at night
❑ Menstrual irregularities ❑ Painful urination

Musculoskeletal

❑ Joint pain ❑ Muscle pain

Neurological

❑ Numbness ❑ Headaches

Psychiatric

❑ Anxiety ❑ Depression ❑ Substance abuse

Endocrine

❑ Cold intolerance ❑ Heat intolerance ❑ Excessive urination

Heme/Lymph

❑ Easy bruising ❑ Enlarged lymph nodes

Are you pregnant, breastfeeding, or do you think you may be pregnant? _____Yes _____No
List all other symptoms you are experiencing that you need to discuss:

We will make every effort to discuss your medical concerns at your visit. However, we may need to schedule an additional appointment to adequately address multiple concerns.