Fisher's Landing Urgent & Family Care

Medical Health History Form

Date________________

Patient Name____
Date of Birth_______________

Reason for visit____

List the medical problems that other doctors have diagnosed:
____
____
____

Surgeries/Hospitalizations:
____
____
____

Are you allergic to any medications? ☐ **Yes** ☐ **No**
Which ones? ____

Current Medications (include doses and non-prescription drugs):
____
____

Tobacco History:
None______ If quit, when? ________ cigarettes/packs per day ________ Years smoked? ________

Alcohol History:
None _____ Average drink per day _____ per week______ per month______ per year______

Any recreational drugs____

Exercise: Type____________________________ Frequency_________________________________

Work: Type of work_____________________________________ Number of years____________

Family History:

	Age	Age at death	Medical problems/ Cause of death
Father	_____	_____	______________________
Mother	_____	_____	______________________
Sibling (s)	_____	_____	______________________
Children	_____	_____	______________________
Maternal grandmother	_____	_____	______________________
Maternal Grandfather	_____	_____	______________________
Paternal Grandmother	_____	_____	______________________
Paternal Grandfather	_____	_____	______________________

OTHER PROBLEMS

As you review the following list, please check any that apply to you recently.

Fisher's Landing Urgent & Family Care

- ☐ **Decreased hearing**
- ☐ **Ringing in ears**
- ☐ **Fainting**
- ☐ **Seizures**
- ☐ **Stroke**
- ☐ **Tremors**
- ☐ **Headaches**
- ☐ **Migraine**
- ☐ **Double/blurred vision**
- ☐ **Eye pain**
- ☐ **Depression**
- ☐ **Anxiety**
- ☐ **Agitation**
- ☐ **Memory loss**
- ☐ **Moodiness**
- ☐ **Phobias**
- ☐ **Suicidal thoughts**
- ☐ **Sleeping problems**
- ☐ **Sinus trouble**
- ☐ **Sore throat**
- ☐ **Hoarseness**
- ☐ **Hay fever/allergies**
- ☐ **Pneumonia/pleurisy**
- ☐ **Bronchitis/chronic cough**
- ☐ **Shortness of breath on exertion**
- ☐ **Shortness of breath lying flat**
- ☐ **Arthritis**
- ☐ **Back pain**
- ☐ **Numbness/tingling**
- ☐ **Foot pain**
- ☐ **Gout**
- ☐ **Bone fracture/joint injury**
- ☐ **Osteoporosis**
- ☐ **Rashes**
- ☐ **Hives**
- ☐ **Psoriasis**
- ☐ **Eczema**
- ☐ **Hair loss**
- ☐ **Mole, changing**
- ☐ **Chest pain**
- ☐ **Irregular pulse**
- ☐ **Palpitations**
- ☐ **Swollen ankles**
- ☐ **Leg pain when walking**
- ☐ **Cold/numb feet**
- ☐ **Varicose veins/phlebitis**
- ☐ **Loss of appetite**
- ☐ **Difficulty swallowing**
- ☐ **Heartburn**
- ☐ **Weight changes**
- ☐ **Persistent vomiting/nausea**
- ☐ **Abdominal pain**
- ☐ **Hernia**
- ☐ **Jaundice/Hepatitis**
- ☐ **Diarrhea**
- ☐ **Constipation**
- ☐ **Diverticulosis**
- ☐ **Hemorrhoid**
- ☐ **Bladder leakage**
- ☐ **Incontinence**
- ☐ **Decreased force/flow**
- ☐ **Pain/burning during urination**
- ☐ **Blood in urine**
- ☐ **Kidney stones**
- ☐ **STDs**

MALES

- ☐ **Testicular pain**
- ☐ **Penile pain/discharge**

FEMALES

- ☐ **Irregular menstrual cycles**
- ☐ **Pain/bleeding during/after sex**
- ☐ **Flushing/menopause**

Date of last PAP_______________

- ☐ **Normal**
- ☐ **Abnormal**

If any of the above boxes were checked, please explain:____

____

____

Patient/Guardian Signature____**Date**_____________

Provider Signature____**Date**______________

Print Patient Name____ **DOB**____________________

How did you hear about us: Phone Book Website Post Card Referral from Doctor or Patient

Please circle an option or write in your answer