**MEDICAL HISTORY AND SCREENING FORM**

*The purpose of preventive exams is to screen for potential health problems and provide education to promote optimal health. It is best practice for chronic health problems to be addressed by your community primary care provider. In keeping with these standards and to promote continuity of care, Sindecuse clinicians will not be providing evaluation or treatment for chronic conditions during preventive exams. Please complete the information below prior to the arriving for registration. Preventive exams will be rescheduled for patients without completed Medical History and Screening Forms.*

# General Information

Name Address Contact phone numbers Birth date

## Family Physician and/or Primary Health Care Provider:

Doctor/Other Address

Phone City

A copy of your visit/labs will be sent to your physician or primary health care provider.

# Past Medical History

## Check those questions to which you answer yes (leave the others blank) & comment below. Have you ever had or do you have any of the following health problems?

 Substance Abuse:

* Alcohol
* Marijuana
* Other drugs

 Bleeding tendency

 Breast disease

 Cancer

* Breast
* Uterine
* Other

 Psychiatry o Depression o Anxiety

* Bipolar
* Eating disorder

 Diabetes

 High cholesterol

 Cardiac

* Heart murmur
* Heart attack
* High blood pressure

 Hepatitis

 Glaucoma

 Dental disease

 Neuro

* Migraine
* Stroke
* Seizure
* Other

 GI

* Jaundice
* Liver disease
* Gallbladder disease
* Gastritis/Ulcer disease
* Acid reflux
* Hemorrhoids
* Other

 Kidney

* Kidney infection
* Bladder infection
* Kidney stones

 Thyroid disorder

 Varicose veins

 Seizure disorder

 Lung

* Sleep apnea
* Asthma
* Chronic Obstructive Pulmonary Disease
* Tuberculosis
* Seasonal allergies
* Other

 Environmental allergies

 Blood clots

 Serious trauma

 Sexually transmitted infection

 Other

## Comments:

**SYMPTOMS**

**Are you currently having or have you recently had any of the following symptoms? Check those questions to which you answer yes (leave the others blank).**

 Fevers

 Night sweats

 Unexplained weight loss/gain

 Fatigue

 Headaches

 Vision problems

 Hearing problems

 Dizziness

 Ringing in ears

 Eye pain

 Ear pain

 Nosebleeds

 Sore throat

 Difficulty swallowing

 Hoarse voice

 Persistent cough

 Coughing up blood

 Chest pain

 Palpitations/irregular heartbeat

 Swelling of extremities

 Shortness of breath

 Lightheadedness

 Change in appetite

 Abdominal pain

* Nausea
* Vomiting
* Diarrhea

 Rectal pain

* Change in bowel habits
* Blood in stool
* Black stool

 Muscle, bone or joint pain

 Leg cramps

 Skin color changes

 Persistent bruising

 Inability to sleep flat

 Change in size/color of mole

 Numbness of extremities

 Muscle weakness

 Tremor

 Urinary symptoms

* Blood in urine
* More frequent urination
* Incontinence/loss of urine
* Pain

 Sexual dysfunction

 Mood changes

 Difficulty sleeping

## Comments:

### SURGERIES:

Type of surgery and specific date or your age at surgery:

### HOSPITALIZATIONS:

List hospitalizations, including dates of and reasons for hospitalization:

### MEDICATIONS:

List any prescription medications (with dosage and frequency of use) you are now taking:

List any self-prescribed medications, dietary supplements, or vitamins (with dosage and frequency of use)

you are now taking:

### ALLERGIES:

List any drug or medical materials (latex) allergies and reaction:

**Family History**

## Indicate illnesses in blood relative (i.e. parents, grandparents, siblings) - Check those questions to which you answer yes (leave the others blank).

 Substance Abuse:

* Alcohol
* Marijuana
* Drugs

 Anemia

 Bleeding or clotting abnormality

 Breast disease

 Cancer

* Prostate
* Skin
* Colon
* Lung
* Breast cancer
* Other

 Diabetes

 Heart disease

 High cholesterol

 High blood pressure

 Mental illness

 Depression

 Suicide

* Sibling
* Parents
* Grandparents

 Migraines/headaches

 Stroke

 Thyroid disorder

 Arthritis

* Rheumatoid
* Osteoarthritis

 Connective tissue disorder

* Lupus
* Scleroderma

## Health and Lifestyle

Do you smoke?

 Yes  No

If you smoke, how many per day? Age started

Are you concerned about your own or someone else’s alcohol abuse? Yes No Have you ever felt you should cut down on your drinking? Yes No Have people annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? Yes  No

Do you often having the feeling of being overwhelmed or depressed?  Yes No Do you exercise? Yes No

If yes, type of exercise:

If yes, frequency of exercise: Do you use a seatbelt at least 90% of the time? Yes No

### Immunization Update: Check box if yes and put date received.

Tetanus:  Date:

Measle, Mumps, Rubella:  Date: Flu Shot:  Date: \_\_\_\_\_\_\_\_\_\_\_

Varicella (chicken pox) vaccine:  Date: \_\_\_\_\_\_\_\_\_\_\_ Pneumovax (pneumonia) vaccine:  Date: \_\_\_\_\_\_\_\_\_\_\_ Zoster (shingles) vaccine:  Date: \_\_\_\_\_\_\_\_\_\_\_

## Sexual History

Have you ever been sexually active? Yes No Are you currently sexually active? Yes No

### Complete the following questions if you are sexually active.

Are you currently having sexual relations with one partner or multiple partners?

One Multiple

Number of partners in last year:

Are you in a monogamous relationship? Yes No Are/Is your sexual partner(s): Men Women Both

Do you and your partner use contraceptive and/or protective methods? Yes No

Have you ever had a sexually transmitted illness (STI) (i.e. HPV, Herpes, Chlamydia, Gonorrhea or other)?

Yes No

List STI: Treated: Yes No

## Gynecologic History

Do you have a period every month? Yes No Number of days of flow:

Menstrual cramps: Mild Moderate Severe None

Date of last PAP smear: Last PAP smear result:

Have you ever had an abnormal PAP smears? Yes No

If yes, explain clinical history (including test location, date, what was done) for any abnormal PAP smear:

Number of pregnancies:

Are you presently trying to become pregnant or will be trying soon? Yes No

Gynecologic symptoms: **Check those questions to which you answer yes (leave the others blank).**

 Abnormal menstrual bleeding

 Missed periods

 Night sweats

 Hot flashes

 Vaginal dryness

Have you ever had a mammogram? Yes No

If applicable, indicate the date and result of your last mammogram:

 History of prescription hormone use

 Mood changes associated with period

 Insomnia