

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 _____

Former Physician and/or Primary Health Care Provider:

Doctor/Other _____ Phone _____ Address _____
City _____

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?

- | | | | |
|---|---|------------------------------------|---|
| <input type="checkbox"/> Substance Abuse: | <input type="checkbox"/> Neuro | | |
| <input type="radio"/> Alcohol | <input type="radio"/> Migraine | <input type="radio"/> Marijuana | <input type="radio"/> Seizure |
| <input type="radio"/> Stroke | <input type="radio"/> Other drugs | <input type="radio"/> Other _____ | |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> GI | | |
| <input type="checkbox"/> Breast disease | <input type="checkbox"/> Liver disease | | |
| <input type="checkbox"/> Cancer | <input type="radio"/> Jaundice | <input type="radio"/> Breast | <input type="radio"/> Liver disease |
| <input type="radio"/> Uterine | <input type="radio"/> Gallbladder disease | <input type="radio"/> Other | |
| <input type="radio"/> Gastritis/Ulcer disease | | | |
| <input type="checkbox"/> Psychiatry | <input type="radio"/> Acid reflux | <input type="radio"/> Depression | |
| <input type="radio"/> Hemorrhoids | <input type="radio"/> Anxiety | <input type="radio"/> Other _____ | <input type="radio"/> Bipolar |
| <input type="checkbox"/> Kidney | | | |
| <input type="radio"/> Eating disorder | <input type="radio"/> Kidney infection | | |
| <input type="checkbox"/> Diabetes | <input type="radio"/> Bladder infection | | |
| <input type="checkbox"/> High cholesterol | <input type="radio"/> Kidney stones | | |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Thyroid disorder | | |
| <input type="radio"/> Heart murmur | <input type="radio"/> Varicose veins | <input type="radio"/> Heart attack | <input type="checkbox"/> Seizure disorder |
| <input type="radio"/> High blood pressure | <input type="checkbox"/> Lung | | |
| <input type="checkbox"/> Hepatitis | <input type="radio"/> Sleep apnea | | |

- Chronic Obstructive Pulmonary Disease
- Tuberculosis
- Seasonal allergies

- Blood clots
- Serious trauma
- Sexually transmitted infection
- Other _____

Glaucoma

- Asthma

Dental disease

- Other

Environmental allergies

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).

- | | | | |
|--|---|--|------------------------------|
| <input type="checkbox"/> <input type="checkbox"/> Fevers | | | |
| <input type="checkbox"/> <input type="checkbox"/> Night sweats | <input type="checkbox"/> <input type="checkbox"/> | | Abdominal pain |
| <input type="checkbox"/> <input type="checkbox"/> Unexplained weight loss/gain | <input type="radio"/> | | Nausea |
| <input type="checkbox"/> <input type="checkbox"/> Fatigue | <input type="radio"/> | | Vomiting |
| <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="radio"/> | | Diarrhea |
| <input type="checkbox"/> <input type="checkbox"/> Vision problems | <input type="checkbox"/> <input type="checkbox"/> | | Rectal pain |
| <input type="checkbox"/> <input type="checkbox"/> Hearing problems | <input type="radio"/> | | Change in bowel habits |
| <input type="checkbox"/> <input type="checkbox"/> Dizziness | <input type="radio"/> | | Blood in stool |
| <input type="checkbox"/> <input type="checkbox"/> Ringing in ears | <input type="radio"/> | | Black stool |
| <input type="checkbox"/> <input type="checkbox"/> Eye pain | <input type="checkbox"/> <input type="checkbox"/> | | Muscle, bone or joint pain |
| <input type="checkbox"/> <input type="checkbox"/> Ear pain | <input type="checkbox"/> <input type="checkbox"/> | | Leg cramps |
| <input type="checkbox"/> <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> <input type="checkbox"/> | | Skin color changes |
| <input type="checkbox"/> <input type="checkbox"/> Sore throat | <input type="checkbox"/> <input type="checkbox"/> | | Persistent bruising |
| <input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> <input type="checkbox"/> | | Inability to sleep flat |
| <input type="checkbox"/> <input type="checkbox"/> Hoarse voice | <input type="checkbox"/> <input type="checkbox"/> | | Change in size/color of mole |
| <input type="checkbox"/> <input type="checkbox"/> Persistent cough | <input type="checkbox"/> <input type="checkbox"/> | | Numbness of extremities |
| <input type="checkbox"/> <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> <input type="checkbox"/> | | Muscle weakness |
| <input type="checkbox"/> <input type="checkbox"/> Chest pain | <input type="checkbox"/> <input type="checkbox"/> | | Tremor |
| <input type="checkbox"/> <input type="checkbox"/> Palpitations/irregular heartbeat | <input type="checkbox"/> <input type="checkbox"/> | | Urinary symptoms |
| <input type="checkbox"/> <input type="checkbox"/> Swelling of extremities | <input type="radio"/> | | Blood in urine |
| <input type="checkbox"/> <input type="checkbox"/> Shortness of breath | <input type="radio"/> | | More frequent urination |
| <input type="checkbox"/> <input type="checkbox"/> Lightheadedness | <input type="radio"/> | | Incontinence/loss of urine |
| <input type="checkbox"/> <input type="checkbox"/> Change in appetite | <input type="radio"/> | | Pain |
| | <input type="checkbox"/> <input type="checkbox"/> | | Sexual dysfunction |
| | <input type="checkbox"/> <input type="checkbox"/> | | Mood changes |
| | <input type="checkbox"/> <input type="checkbox"/> | | 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 and indicate what relative.

- | | |
|--|--|
| <input type="checkbox"/> <input type="checkbox"/> Substance Abuse: <input type="radio"/> Alcohol <input type="radio"/> Marijuana <input type="radio"/> Drugs | <input type="checkbox"/> <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding or clotting abnormality | <input type="checkbox"/> <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> <input type="checkbox"/> Breast disease | <input type="checkbox"/> <input type="checkbox"/> Depression |
| <input type="checkbox"/> <input type="checkbox"/> Cancer <input type="radio"/> Prostate <input type="radio"/> Skin <input type="radio"/> Colon | <input type="checkbox"/> <input type="checkbox"/> Suicide |
| <input type="radio"/> Lung | <input type="radio"/> Sibling |
| <input type="radio"/> Breast cancer <input type="radio"/> Other _____ | <input type="radio"/> Parents |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="radio"/> Grandparents |
| <input type="checkbox"/> <input type="checkbox"/> Heart disease | <input type="checkbox"/> <input type="checkbox"/> Migraines/headaches |
| <input type="radio"/> Scleroderma | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| | <input type="checkbox"/> <input type="checkbox"/> Thyroid disorder |
| | <input type="checkbox"/> <input type="checkbox"/> Arthritis |
| | <input type="radio"/> Rheumatoid |
| | <input type="radio"/> Osteoarthritis |
| | <input type="checkbox"/> <input type="checkbox"/> Connective tissue disorder |
| | <input type="radio"/> Lupus |

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 have 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

History of prescription hormone use

Mood changes associated with period Insomnia

Have you ever had a mammogram? Yes No

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