SAN TAN URGENT CARE HEALTH CENTER
Health History Sheet

Today's Date:_____

Patient's Name:_____ Date of Birth:_____ Age:_____

This history form provides us with information to help us meet all your health care needs, please complete this form answering each question. **This is a confidential part of your medical record and will be kept in this office.**

BASIC INFORMATION

1. Occupation: _____ 2. Marital Status: _____
3. Exercise / Recreation: _____

HABITS

1. Do you a smoke? Y or N If so, # packs a day? _____ Ever quit smoking? Y or N Date: _____
2. Do you drink alcohol? Y or N How often? _____ Drink caffeine? Y or N How often? _____
3. Do you use recreation drugs? Y or N Type: _____ How often:_____

PATIENT HISTORY

Yes	No	Coronary Artery Disease (CAD)
Yes	No	Essential Hypertension
Yes	No	Hyperlipidemia
Yes	No	Diabetes Type- I or II
Yes	No	HIV Infection
Yes	No	Asthma

- Please list **ALL** allergies you may have to medications, foods, and environment

1._____ 2. _____

3._____ 4._____

5._____ 6._____

- Please list **ALL operations, conditions, and hospitalizations** you have experienced, also include the years these occurred.

1._____

2._____

3._____

- Please list **ALL medications** your are currently taking (include nonprescription drugs)

1._____ 4._____

2._____ 5._____

3._____ 6._____

- **Last Menstrual Period** (LMP): Date:_____

PLEASE LIST REASON FOR VISIT

Please list (in order of importance) health concern, symptoms, or problems you are experiencing,

_____

PRESENT ILLNESS / INJURY / CONCERNS: (Please circle YES for all that apply to your visit today)

Systemic symptoms
Yes weight changes
Yes fever
Yes chills
Yes night sweats
Yes feeling tired or poorly
Other: _____

Head symptoms
Yes headaches
Yes facial pain
Yes sinus pain
Other: _____

Eye symptoms
Yes eyesight problems
Yes sensitive to light
Yes eye pain
Yes itching of the eyes
Other: _____

Otolaryngeal symptoms
Yes earache
Yes hearing loss
Yes ringing in ears
Yes nosebleeds
Yes nasal discharge
Yes mouth sores
Yes bleeding gums
Yes hoarseness
Yes throat pain
Other: _____

Pulmonary symptoms
Yes shortness of breath
Yes cough
Yes coughing up blood
Yes night sweats
Yes wheezing
Other: _____

Genitourinary symptoms
Yes painful urination
Yes increased urination
Yes blood in urine
Yes genital lesions
Other: _____

Musculoskeletal symptoms
Yes joint pain, localized
Yes joint stiffness, localized
Yes muscle aches
Other: _____

Neck symptoms
Yes neck pain
Yes neck stiffness
Yes lumps or swelling in neck
Other: _____

Breast symptoms
Yes breast pain
Yes nipple discharge
Yes breast lumps
Other: _____

Cardiovascular symptoms
Yes chest pain or discomfort
Yes fast heart rate
Yes palpitations
Other: _____

Gastrointestinal symptoms
Yes change of appetite
Yes difficulty swallowing
Yes heartburn
Yes nausea
Yes vomiting
Yes abdominal pains
Yes diarrhea
Yes black or bloody stools
Other: _____

Endocrine symptoms
Yes excessive sweating
Yes excessive thirst
Yes libido has changed
Other: _____

Skin symptoms
Yes itching
Yes skin lesions
Yes rashes
Other: _____

Neurological symptoms
Yes dizziness
Yes vertigo
Yes fainting
Yes motor disturbances
Yes sensory disturbances
Other: _____

Psychological symptoms
Yes sleep disturbances
Yes anxiety
Yes depression
Other: _____

FAMILY HISTORY (Please list *any family member* who has/had any of the following?)

Yes No Cancer _____
Yes No Heart Disease _____
Yes No High Blood Pressure/Hypertension _____
Yes No Early Deaths _____
Yes No Depression _____
Yes No Stroke _____
Yes No Obesity _____
Yes No Migraine Headaches _____
Yes No High Cholesterol _____
Yes No Drug/Alcohol problems _____
Other: _____

- Please list family member's health status: (Health is **GOOD, FAIR, POOR, or DECEASED at / AGE**)

Mother- _____ Siblings- _____

Father- _____ Children- _____

IMMUNIZATIONS

All immunizations up to date Yes or No

Tetnus with in last 10 yrs Yes or No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is also my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the staff to perform the necessary health care services I may need.

Signature_____ Date_____