POLYCLINIC

PLEASE PRINT THIS INFORMATION BECOMES PART OF YOUR CONFIDENTIAL MEDICAL RECORD. **PLEASE PRINT**

NAME _____

LAST FIRST MIDDLE INITIAL

How would you like to be addressed by our staff (i.e., Mr./Ms. or first name)? _____

ADDRESS _____

_____

PHONE(s) _____

Type of Work _____

Marital/Partner Status _____

Education (years completed)

GRADE_____ HIGH _____ VOCATIONAL _____ COLLEGE _____

Previous Primary Care Physician _____

Other treating physician(s) _____

Last eye exam_____ Last dental exam _____

Last tetanus shot _____

PAST HISTORY (GIVE NAMES AND DATES)

PREVIOUS SURGERY	
PREVIOUS HOSPITALIZATIONS MAJOR ILLNESS OR INJURY	

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS: NUMBER:_____			
SISTERS: NUMBER:_____			
CHILDREN: NUMBER:_____			

CHECK IF ANY RELATIVES HAVE HAD:

- DIABETES ☐
- HEART TROUBLE ☐
- HEART ATTACK ☐
- HIGH BLOOD PRESSURE ☐
- STROKE ☐
- CANCER ☐
- TUBERCULOSIS ☐
- MELANOMA ☐
- ARTHRITIS ☐
- OBESITY (OVERWEIGHT) ☐
- SUICIDE ☐
- MENTAL ILLNESS ☐
- THYROID TROUBLE ☐

_____

NUMBER LIVING IN YOUR HOUSEHOLD _____

SMOKING:	ALCOHOL:	CAFFEINE	WEAR HELMET WHEN BIKING?	SMOKE ALARMS?	ANY RISK FACTORS FOR HEPATITIS OR AIDS
PACKS PER DAY_____	PER DAY _____	(coffee, tea, cola):	☐YES ☐NO	☐YES ☐NO	(SUCH AS BLOOD TRANSFUSIONS, SEXUAL CONTACTS, IV DRUG USE)?
NO. YEARS _____	PER WEEK _____	CUPS PER DAY _____			☐YES ☐NO
YEAR STOPPED_____	ALCOHOL PROBLEM	ASPIRIN	USE CAR SEAT BELTS?		☐LET'S DISCUSS
☐PIPE ☐CIGAR ☐CHEW	☐YES ☐NO	TABS PER DAY _____	☐YES ☐NO		

WEIGHT: CURRENT_____ 1 YEAR AGO _____ GOAL: _____ HEIGHT:_____

DRUGS FREQUENTLY OR PRESENTLY USED

Prescription Drugs	Over the counter Drugs and Supplments	Herbal

SPECIFY ANY DRUG REACTION OR ALLERGY: _____

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SYSTEM REVIEW: CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR FINDINGS TO AN UNUSUAL OR SIGNIFICANT DEGREE:

HEADACHE ☐
FAINTING ☐
DIZZINESS ☐
SEIZURE ☐
EAR TROUBLE ☐
SINUS TROUBLE ☐
STUFFY NOSE ☐
NOSE BLEEDS ☐
ALLERGY ☐
HOARSENESS ☐

COUGH ☐
WHEEZING ☐
PLEURISY ☐
PNEUMONIA ☐
TUBERCULOSIS ☐
SHORTNESS OF BREATH ☐
NIGHT SWEATS ☐
CHEST PAIN ☐
COUGHED UP BLOOD ☐
ASTHMA ☐

TROUBLE SWALLOWING ☐
LOSS OF APPETITE ☐
INDIGESTION ☐
HEART BURN ☐
NERVOUS STOMACH ☐
ULCERS ☐
VOMITING BLOOD ☐
PASSING BLOOD ☐
ABDOMINAL PAIN ☐
COLITIS ☐
DIARRHEA ☐
CONSTIPATION ☐
HEMORRHOIDS ☐
CHANGE IN BOWEL HABITS ☐
GALL BLADDER TROUBLE ☐
YELLOW JAUNDICE (HEPATITIS) ☐
LIVER DISEASE ☐

ANEMIA ☐
BLOOD DISORDER ☐
SKIN TROUBLE ☐
TUMOR OR SWELLING ☐

HEART TROUBLE ☐
HEART MURMUR ☐
RHEUMATIC FEVER ☐
PALPITATION ☐
IRREGULAR HEART BEAT... ☐
TIRE EASILY ☐
ANGINA ☐
ENLARGED HEART ☐
HIGH BLOOD PRESSURE ☐
ANKLE SWELLING ☐

ARTHRITIS ☐
BACK PAIN ☐
BURSITIS ☐
MUSCLE CRAMPS ☐
NUMBNESS ☐
VARICOSE VEINS ☐
PHLEBITIS ☐

ABNORMAL ELECTRO-CARDIOGRAM (EKG) ☐
ABNORMAL X-RAY ☐
HIGH BLOOD SUGAR ☐
LOW BLOOD SUGAR ☐

DIABETES ☐
HYPOGLYCEMIA ☐
THYROID TROUBLE ☐
G0ITER ☐
HOT FLASHES ☐
FLUID RETENTION ☐
WEAKNESS ☐
NERVOUS ☐
IRRITABLE ☐
DEPRESSED ☐
TIRED ☐
TROUBLE SLEEPING ☐

KIDNEY TROUBLE ☐
URINE INFECTION ☐
DIFFICULTY URINATING ☐
PROSTATE TROUBLE ☐
SUGAR IN URINE ☐
BLOOD IN URINE ☐
INFERTILITY ☐
IMPOTENCE ☐
DECREASED LIBIDO ☐
OTHER ☐

ACTIVITY (CHECK ONE OR MORE BOXES):

I SEDENTARY LIFE WITH LITTLE EXERCISE ☐

II MILD EXERCISE WITH JOB, HOUSE OR RECREATION (CLIMB STAIRS, WALK OVER 3 BLOCKS, GOLF, BOWL, ETC.) ☐

III OCCASIONAL VIGOROUS ACTIVITY WITH WORK OR RECREATION ☐

IV REGULAR VIGOROUS EXERCISE PROGRAM OR HARD WORK ☐

FOR WOMEN ONLY

DATE LAST MENSTRUATED?_____

PERIOD EVERY _____ DAYS

ANY MENSTRUAL PROBLEMS: ☐YES ☐NO

HEAVY PERIODS _____ IRREGULAR PERIODS_____

INFREQUENT PERIODS _____ PAINFUL PERIODS_____

NUMBER OF PREGNANCIES _____

NUMBER OF MISCARRIAGES_____

BIRTH CONTROL METHOD (IF ANY)_____

DATE OF LAST MAMMOGRAM:_____

PAP SMEAR:_____

CHECK IF YOU HAVE HAD:

☐ D&C ☐ HYSTERECOMY ☐ DIFFICULT WITH PREGNANCY

☐ TOXEMIA ☐ CESAREAN SECTION ☐ DIFFICULTY WITH LABOR

☐ ABNORMAL PAP ☐ DIFFICULTY WITH DELIVERY

FOR WOMEN ONLY

FORM FILLED OUT BY: _____
SIGNATURE

PROVIDER: _____DATE:_____