COMMUNITY HEALTH INTERVENTIONS, INC. SPECIALTY CLINIC

MEDICAL HISTORY AND SCREENING FORM

General Information

Patient:

Name _____

Address_____

Contact phone numbers _____

Birth date _____

Family Physician and/or Primary Health Care Provider:

Doctor/Other _____ Phone _____

Address _____ _____

City/State_____ _____

Reason for initial visit_____

☐ Male ☐Female ☐Other _____

❑Caucasian ❑African American ❑Hispanic ❑Asian

❑Other_____

Education:

☐High School ☐ College (2-4 years) ☐Graduate School

☐Degree _____

Occupation:

Position _____ _____

Employer Address _____ _____

Phone _____

Emergency Contact:

Name_____(Relation)_____

Address_____

Phone_____

Present Medical History

Check those questions to which you answer yes (leave the others blank).

- ☐ Has a doctor ever said your blood pressure was too high?
- ☐ Do you ever have pain in your chest or heart?
- ☐ Are you often bothered by a thumping of the heart?
- ☐ Does your heart often race?
- ☐ Do you ever notice extra heartbeats or skipped beats?
- ☐ Are your ankles often badly swollen?
- ☐ Do cold hands or feet trouble you even in hot weather?
- ☐ Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing?
- ☐ Do you get out of breath long before anyone else?
- ☐ Do you sometimes get out of breath when sitting still or sleeping?
- ☐ Has a doctor ever told you your cholesterol level was high?
- ☐ **Has a doctor ever told you that you have an abdominal aortic aneurysm?**
- ☐ **Has a doctor ever told you that you have critical aortic stenosis?**

Comments: _____

_____

_____

_____

Do you now have or have you recently experienced:

- ☐ Chronic, recurrent or morning cough?
- ☐ Episode of coughing up blood?
- ☐ Increased anxiety or depression?
- ☐ Night Sweats
- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Swollen or painful knees or ankles?
- ☐ Swollen, stiff or painful joints?
- ☐ Pain in your legs after walking short distances?
- ☐ Foot problems?
- ☐ Back problems?
- ☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhea?
- ☐ Significant vision or hearing problems?
- ☐ Recent change in a wart or a mole?
- ☐ Glaucoma or increased pressure in the eyes?
- ☐ Exposure to loud noises for long periods?
- ☐ An infection such as pneumonia accompanied by a fever?

- ☐ Significant unexplained weight loss?
- ☐ A fever, which can cause dehydration and rapid heart beat?
- ☐ A deep vein thrombosis (blood clot)?
- ☐ A hernia that is causing symptoms?
- ☐ Foot or ankle sores that won't heal?
- ☐ Persistent pain or problems walking after you have fallen?
- ☐ Eye conditions such as bleeding in the retina or detached retina?
- ☐ Cataract or lens transplant?
- ☐ Laser treatment or other eye surgery?

Comments: _____
_____
_____
_____

Women only answer the following. Do you have:

- ☐ Menstrual period problems?
- ☐ Significant childbirth - related problems?
- ☐ Urine loss when you cough, sneeze or laugh?

Date of the last pelvic exam and / or Pap smear _____

Comments: _____
_____
_____
_____

Are you on any type of hormone replacement therapy? ___ Date of last complete physical examination:

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last chest X-ray: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last electrocardiogram (EKG or ECG): _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

Date of last dental check up: _____

☐ Normal ☐ Abnormal ☐ Never ☐ Can't remember

List any other medical or diagnostic test you have had in the past two years: _____
_____
_____

List hospitalizations, including dates of and reasons for hospitalization: _____
_____
_____

List any drug allergies: _____
_____
_____

Past Medical History

Check those questions to which your answer is yes (leave others blank).

- ☐ Heart attack if so, how many years ago? _____
- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Arthritis of legs or arms
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Phlebitis (inflammation of a vein)
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ HIV
- ☐ Hepatitis
- ☐ Syphilis
- ☐ Diphtheria
- ☐ Scarlet Fever
- ☐ Infectious mononucleosis
- ☐ Nervous or emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs or joint
- ☐ Broken bones
- ☐ Jaundice or gall bladder problems

Comments: _____
_____
_____
_____

Do you have a history of the following?

- ❑ Drugs/Substance Abuse If yes, how long?_____
- ❑ Alcohol If yes, how long?_____

Have you ever received substance abuse treatment? ❑Yes ❑No

Family Medical History

Father:

☐ Alive Current age _____

My father's general health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reason for poor health: _____

☐ Deceased ☐ Age at death _____

Cause of death: _____

Mother:

☐ Alive Current age _____

My mother's general health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Reason for poor health:_____

☐ Deceased ☐ Age at death _____

Cause of death: _____

Siblings:

Number of brothers _____ Number of sisters _____ Age range _____
Health problems _____

Family Diseases

Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)?

Check those to which the answer is yes (leave other blank).

- ☐ Heart attacks under age 50
- ☐ Strokes under age 50
- ☐ High blood pressure
- ☐ Elevated cholesterol
- ☐ Diabetes
- ☐ Asthma or hay fever
- ☐ Congenital heart disease (existing at birth but not hereditary)
- ☐ Heart operations
- ☐ Glaucoma
- ☐ Obesity (20 or more pounds overweight)
- ☐ Leukemia or cancer under age 60

Smoking

Have you ever smoked cigarettes, cigars or a pipe?

☐ Yes ☐ No

Comments: _____

_____

_____

_____

Medications (Please list current medications – Prescribed and Over the Counter, including vitamins, herbs etc..)

Name of Medication	Dose (Milligrams)	Frequency (How often is medication taken?)	Why is medication used?