

Eye symptoms

- Yes No eyesight problems
- Yes No photophobia
- Yes No eye pain
- Yes No itching of the eyes

Other: _____

Otolaryngeal symptoms

- Yes No earache
- Yes No hearing loss
- Yes No ringing in the ears
- Yes No nosebleeds
- Yes No nasal discharge
- Yes No mouth sores
- Yes No bleeding gums
- Yes No hoarseness
- Yes No throat pain

Other: _____

Neck symptoms

- Yes No neck pain
- Yes No neck stiffness
- Yes No lumps or swelling in the neck

Other: _____

Breast symptoms

- Yes No breast pain
- Yes No nipple discharge
- Yes No breast lumps

Other: _____

Cardiovascular symptoms

- Yes No chest pain or discomfort
- Yes No fast heart rate
- Yes No palpitations

Other: _____

Pulmonary symptoms

- Yes No shortness of breath
- Yes No cough
- Yes No coughing up blood
- Yes No night sweats
- Yes No wheezing

Other: _____

Gastrointestinal symptoms

- Yes No change of appetite
- Yes No difficulty swallowing
- Yes No heartburn
- Yes No nausea
- Yes No vomiting
- Yes No abdominal pains
- Yes No diarrhea
- Yes No black or bloody stools

Other: _____

Genitourinary symptoms

- Yes No dysuria
- Yes No increased urination
- Yes No hematuria
- Yes No genital lesions

Other: _____

Endocrine symptoms

- Yes No excessive sweating
- Yes No excessive thirst
- Yes No libido has changed

Other: _____

Skin symptoms

- Yes No puritis
- Yes No skin lesions
- Yes No rashes

Other: _____

Musculoskeletal symptoms

- Yes No joint pain, localized
- Yes No joint stiffness, localized
- Yes No no muscle aches

Other: _____

Neurological symptoms

- Yes No dizziness
- Yes No vertigo
- Yes No fainting
- Yes No motor disturbances
- Yes No sensory disturbances

Other: _____

Psychological symptoms

- Yes No sleep disturbances
- Yes No anxiety
- Yes No depression

Other: _____

PAST MEDICAL HISTORY

- Yes No Past medical history unchanged
- Yes No Coronary artery disease
- Yes No Essential hypertension
- Yes No Hyperlipidemia
- Yes No Diabetes Type I or II
- Yes No HIV Infection
- Yes No Asthma

FAMILY HISTORY

(Has any family member had any of the following?)

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

Other: _____

- Yes No All immunizations up to date
- Yes No Tetanus within last 10 years

Please list the current conditions of the following members:
(Health is good, fair, poor, or deceased/age)

- Mother _____
- Father _____
- Siblings _____
- Children _____

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 _____

San Tan Urgent Care Health Center
Health History Sheet

Today's Date: _____

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

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

BASIC INFORMATION

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

HABITS

- 1. Are you a smoker? Y or N If so, how many packs a day: _____
Have you ever quit smoking? Y or N Date: _____
- 2. Do you drink alcohol? Y or N How often: _____
- 3. Do you drink caffeinated products? Y or N How often: _____
- 4. Do you use recreation drugs? Y or N
Type: _____ How often: _____

HISTORY

Please list ALL allergies you may have (medications, foods, environment)

- 1. _____
- 2. _____
- 3. _____

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

- 1. _____
- 2. _____
- 3. _____

Please list ALL medications you are currently taking (include nonprescription drugs)

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing (why you are here today).

HISTORY OF PRESENT ILLNESS

____ Systemic symptoms
Yes No weight changes
Yes No fever
Yes No chills
Yes No night sweats
Yes No feeling tired or poorly
Other: _____

____ Head related symptoms
Yes No headaches
Yes No facial pain
Yes No sinus pain
Other: _____