MedCare associates

Patient Name: _____ Today's Date: _____

SS/HIC/Patient ID # _____ Age: _____ Birthdate: _____

What is your reason for visit? _____

Symptoms Check ☑ symptoms that you have

General
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Fatigue

Eye, Ear, Nose, Throat
- ☐ Vision problem or change
- ☐ Hearing problem or change

Pain or drainage from:
- ☐ Eyes
- ☐ Ears
- ☐ Nose/sinus
- ☐ Mouth/throat

Neck
- ☐ Lumps
- ☐ Goiter
- ☐ Pain
- ☐ Stiffness

Breast
- ☐ Lumps
- ☐ Pain
- ☐ Nipple discharge
- ☐ Swelling/enlargement

Pulmonary
- ☐ Cough
- ☐ Productive sputum
- ☐ Wheeze
- ☐ Shortness of breath
- ☐ Sleep on more than 1 pillow

Cardiac
- ☐ Chest pain at rest
- ☐ Chest pain on exertion
- ☐ Murmur
- ☐ Palpitations

Vascular
- ☐ Pain calves when walking
- ☐ Leg cramps
- ☐ Varicose veins
- ☐ Clots
- ☐ Swelling of ankles

Gastrointestinal
- ☐ Heartburn/Indigestion/gas
- ☐ Pain or problem swallowing
- ☐ Stomach pain
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloating/distension
- ☐ Mass
- ☐ Change in bowel habits
- ☐ Vomiting blood
- ☐ Rectal Bleeding
- ☐ Melena (tarry black stools)
- ☐ Hemorrhoids

Urinary
- ☐ Frequent urination
- ☐ Urgency
- ☐ Pain with urination
- ☐ Blood in urine
- ☐ Hesitancy with urination
- ☐ Incontinence
- ☐ Stones
- ☐ Recurrent UTI's

Endocrine
- ☐ Thyroid problem
- ☐ High glucoses
- ☐ Low glucoses
- ☐ Increased thirst
- ☐ Increased sweats
- ☐ Heat intolerance
- ☐ Cold intolerance

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ Stiffness
- ☐ Gout
- ☐ Neck pain
- ☐ Back pain
- ☐ Change in mobility

Neuropsychiatric
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Weakness
- ☐ Paralysis
- ☐ Numbness/tingling
- ☐ Tremors
- ☐ Headaches
- ☐ Depressed mood
- ☐ Sleep increased or decreased
- ☐ Interest activities decreased
- ☐ Guilt/worthless feelings
- ☐ Energy low/fatigue
- ☐ Concentration difficulty
- ☐ Appetite increased or decreased
- ☐ Increased anxiety or agitation
- ☐ Suicidal thoughts

Heme
- ☐ Anemia
- ☐ Increased Bleeding
- ☐ Increased Bruising
- ☐ Transfusions
- ☐ Familial d/o (clotting/bleeding)

Skin
- ☐ Rash
- ☐ Lumps
- ☐ Sores or ulcers
- ☐ Dryness
- ☐ Color changes
- ☐ Hair changes
- ☐ Nail changes
- ☐ Hives
- ☐ Itching

Women Only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Painful intercourse
- ☐ Vaginal discharge

Date of last menstrual period: _____ Date of last mammogram: _____

Date of last pap smear: _____ Method of contraception _____

Number of pregnancies: _____ Number of live births: _____

Number of miscarriages: _____ Number of abortions: _____

Number of living children: _____ Are you pregnant? _____

Men Only
- ☐ Sexual difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis

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Medical Conditions

Check ☑ conditions that you have or have had

Condition	Type?	Onset date?	Condition	Type?	Onset Date?
☐ Alcohol dependence			☐ High blood pressure		
☐ Allergies/hay fever			☐ High cholesterol		
☐ Anemia			☐ HIV/AIDS		
☐ Anorexia/Bulimia			☐ Hypothyroid		
☐ Angina/Chest pain/Heart attack			☐ Hyperthyroid		
☐ Arthritis			☐ Irregular or fast heart beat		
☐ Asthma			☐ Mitral Valve Prolapse		
☐ Autoimmune disease (Lupus, Sjogren's, Scleroderma…)			☐ Memory problem/Dementia		
☐ Bleeding / Clotting disorder			☐ Mononucleosis		
☐ Cataracts			☐ Neuromuscular disorder		
☐ Cancer			☐ Obesity		
☐ Chronic bronchitis/Emphysema			☐ Pacemaker		
☐ Chronic kidney disease			☐ Polio		
☐ Chronic liver disease			☐ Prostrate problem		
☐ Colon disorder(Ulcerative colitis, Crohn's,Diverticulitosis,IBS…)			☐ Psychiatric (Anxiety, Bipolar, Depression, Anxiety, ADD…)		
☐ Congestive Heart Failure or enlarged heart			☐ Rheumatic Fever		
☐ Chicken Pox/Shingles			☐ Seizures/Epilepsy		
☐ Diabetes I or II			☐ Sinus infections		
☐ Drug dependency			☐ Stomach ulcers		
☐ Fibromyalgia			☐ Stroke or mini-stroke		
☐ Glaucoma			☐ Suicide Attempt		
☐ Goiter/thyroid nodules			☐ Sexually Transmitted Disease		
☐ Gout			☐ Sickle Cell anemia		
☐ Headaches			☐ Tuberculosis		
☐ Head injury			☐ Urinary Tract Infections		
☐ Heartburn			☐ Vaginal Infections		
☐ Hemorrhoids/rectal problems			☐ Valve disease / heart murmur		
☐ Hepatitis			☐ Vascular disease (carotid, heart, renal, peripheral arteries)		
☐ Hernia			☐ Vein problems / cellulitis / leg ulcers		
☐ Other			☐ Other		

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Medications List medications, supplements, and herbs you are currently taking

Medication	*Dosage*	*Frequency*	*Medication*	*Dosage*	*Frequency*

Allergies to medications and foods (describe reaction like rash, anaphylactic shock…)

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed ☐ Partnered

Are you sexually active? ☐ Yes ☐ No

Have you ever been physically or verbally abused by a partner? ☐ Yes ☐ No

Health Habits Check ☑ substances you use and describe how much you use

☐ Tobacco

☐ Alcohol

☐ Drugs

☐ Caffeine

Occupational Check ☑ if your work exposes you to the following:

☐ Stress	☐ Hazardous Substances
☐ Heavy Lifting	☐ Other

Occupation:

Family History

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check ☑ if your blood relatives had any of the following:

Disease	Relationship to you
☐ Arthritis, Gout	
☐ Asthma, Allergies	
☐ Cancer	
☐ Chemical Dependency	
☐ Diabetes	
☐ Heart Disease, Strokes	
☐ High Blood Pressure or cholesterol	
☐ Kidney or Liver Disease	
☐ Tuberculosis	
☐ Mental Disorder	

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Surgeries

Date	Hospital	Surgery or Illness

Serious Illnesses/Hospitalizations

Vaccines

Vaccines	Date of last vaccine
Influenza (1 per year)	
Pneumococcal (1 or 2)	
Tetanus—Td every 10 yrs	
Tetanus—TdaP (1)	
Hepatitis B series (3)	
Hepatitis A series (2)	
MMR (1 before & after 50)	
HPV (gardasil or cervarix—3)	
Meningococcal (1)	
Zostavax (2 over 60)	
Varicella (2 if no chickenpox)	
Other	

**** Have you ever had a blood transfusion?** ☐ **Yes** ☐ **No** If yes, give approximate date: _____

Pregnancy Complications

Year	Complication

DO YOU HAVE ADVANCED DIRECTIVES? ☐ Yes ☐ No

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his / her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ *Date:* _____

Reviewed By: _____ Date: _____