FOR CLINIC USE ONLY: WT_____ HT_____ TEMP_____ PULSE_____ O2_____ RESP_____ B/P_____

Today's Date: _____

Brickie Community Health Clinic

Patient Name: _____

Parent/Guardian Name: _____

Date of Birth: _____

Reason for visit: _____

_____

Primary Care Provider/Pediatrician:_____

CURRENT SYMPTOMS:

***FEMALES ONLY**: Date of last menstrual period:_____ Could you be pregnant?_____*

Number of pregnancies:_____ Number of births:_____

PAIN?_____ WHERE?_____

• Change in appetite?	NO	YES	Dizziness or fainting?	NO	YES
• Weight gain/loss?	NO	YES	Anxiety or depression?	NO	YES
• Activity or sleep change?	NO	YES	Frequent or painful urination?	NO	YES
• Headache?	NO	YES	Constipation?	NO	YES
• Congestion or facial pain?	NO	YES	Diarrhea?	NO	YES
• Sore throat or trouble swallowing?	NO	YES	Unusual bleeding?	NO	YES
• Earache? Right or Left?	NO	YES	Rash or skin problems?	NO	YES
• Cough? Productive?	NO	YES	Itching?	NO	YES
• Shortness of breath or wheezing?	NO	YES	Wounds or sores?	NO	YES
• Fast heartbeat?	NO	YES	Joint pain or swelling?	NO	YES
• Chest pain?	NO	YES			

PAST HISTORY:

• High Blood pressure	NO	YES
• Diabetes	NO	YES
• Stroke	NO	YES
• Heart murmur	NO	YES
• Heart disease	NO	YES
• Asthma	NO	YES
• Allergies	NO	YES
• Attention Deficit Disorder	NO	YES
• Reflux disease	NO	YES
• COPD/Emphysema	NO	YES
• Gallbladder disease	NO	YES
• Anemia	NO	YES
• Chicken Pox	NO	YES
• Hepatitis	NO	YES

OTHER_____

_____

HOSPITALIZATIONS OR SURGERIES

_____

_____

_____

_____

Do you smoke? _____ If yes, packs daily: _____
Smoked how long: _____ When stopped: _____

Do you drink alcohol? NO YES
Type/Amount per week:_____

In the last year, have you had any of the following?
Physical Exam:____ Pap Smear:____ Eye exam:_____
Rectal/Prostate exam:_____ Colonoscopy:_____
Mammogram:_____ Bone Density:_____

In the last year have you had any of the following vaccines?
Tetanus: _____ Pneumonia: _____ Hepatitis B: _____
Flu Shot: _____ TB Test: _____ MMR: _____

***Any other concerns you would like to talk about today? _____**

_____

DRUG ALLERGIES

_____ _____

_____ _____

_____ _____

FAMILY HISTORY

	Father	Mother	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Siblings	Children
Heart disease								
High blood pressure								
Stroke								
Cancer								
Glaucoma								
Diabetes								
Epilepsy/Convulsion								
Bleeding disorder								
Kidney disease								
Thyroid disease								
Mental illness								

Number of Brothers & ages: _____ Sisters & ages: _____

Your Preferred Pharmacy: _____ Location: _____
(example-CVS) (example-Lake Park Ave, Hobart)

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING & THOSE USED AS NEEDED (OTC & SUPPLEMENTS INCLUDED)

NAME OF MEDICATION	DOSAGE	FREQUENCY