

FOR CLINIC USE ONLY: WT _____ HT _____ TEMP _____ PULSE _____ O2 _____ RESP _____ B/P _____

BRICKIE COMMUNITY HEALTH CLINIC



Date: _____

Patient Name: _____

Date of Birth: _____

Reason for visit: _____

Primary Care Provider: _____

FEMALES ONLY: Date of last menstrual period: _____ Could you be pregnant? _____
Number of Pregnancies: _____ Number of births: _____

CURRENT SYMPTOMS:

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

Allergies	NO YES	Depression	NO YES
Anemia	NO YES	Diabetes mellitus	NO YES
Anxiety	NO YES	Emphysema	NO YES
Arthritis	NO YES	GERD	NO YES
Asthma	NO YES	Glaucoma	NO YES

ADD/ADHD	NO YES	Heart murmur	NO YES
Blood Transfusion	NO YES	HIV/AIDS	NO YES
Cancer	NO YES	High Cholesterol	NO YES
Cataracts	NO YES	High Blood Pressure	NO YES
Chicken Pox	NO YES	Kidney disease	NO YES
CHF	NO YES	Meningitis	NO YES
Clotting disorder	NO YES	Nerve/Muscle Disease	NO YES
COPD	NO YES	Seizures	NO YES
Osteoporosis	NO YES	Strep Throat (recurrent)	NO YES
Scoliosis	NO YES	Stroke	NO YES
Substance Abuse	NO YES	Thyroid Disease	NO YES
Tuberculosis	NO YES		

HOSPITALIZATIONS OR SURGERIES

Do you Smoke? _____
If yes, packs daily? _____
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: _____ Eye Exam: _____

In the last year, have you had any of the following vaccine?

Tetanus: _____ Pneumonia: _____

Hepatitis B: _____ Flu Shot: _____ TB Test: _____

MMR: _____

ADULTS ONLY (18 & OVER)

Rectal/Prostate Exam: _____ Colonoscopy: _____

Mammogram: _____ Bone Density: _____ Pap Smear: _____

Names of Brothers	Age
Names of Sisters	Age

Your Preferred Pharmacy: _____ **Location:** _____
(Example—CVS) (Example—Lake Park Ave., Hobart)

[illegible]