Stafford Primary Care
P.O. Box 249
Garrisonville, VA 22463

Patient Medical History

Stafford Urgent Care
P.O. Box 729
Garrisonville, VA 22463

Last Name _____ First Name _____ Date of Birth ___/___/_____ Age _____ Today's Date ___/___/___

Occupation _____ Race (Circle One) *Caucasion Black Hispanic Other:*

Reason for Appointment _____

Medications Presently Taking (Dose & Frequency) _____

Allergies _____

Yes/No Alcohol Use?
How Much _____
How Long _____

Yes/No Tobacco Use?
How Much _____
How Long _____

Past Medical History

Have you had or do you have any of the following illnesses/disease(s)?

	YES	NO
1. Rheumatic Fever		
2. Scarlet Fever		
3. Infectious Mono		
4. Measles		
5. Chickenpox		
6. Pneumonia		
7. High Blood Pressure		
8. Diabetes (high blood sugar)		
9. Heart Disease/problems		
10. Migraine Headaches		
11. Stomache Ulcers		
12. Liver disease/problems		
13. Pancreas problems		
14. Gallbladder disease/problem		
15. Jaundice (yellowish colored skin)		
16. Colitis (episodes of diarrhea)		
17. Kidney disease/infections		
18. Kidney stones/renal stones		
19. Asthma		
20. Bronchitis		
21. Emphysema		
22. Tumors		
23. Arthritis		
24. V.D. (Venereal Disease)		
Gonorrhea		
Syphilis		
Chlamydia		
25. T.B. skin test		
Year last test done _____		
Test results: + or - (circle one)		
26. Treated for T.B.		
Year and length of treatment _____		
27. Have you had HIV test		
Test results: + or - (circle one)		
When last HIV test done _____		
28. Seizures, convulsions		
29. Confinement by illness or injury		
30. Psychiatric disorder		
31. Any other nervous disorder		
32. Head or spinal injuries		
33. History of trauma		
34. Do you have an "Advanced Directive"?		

If the answer to any of the above questions is yes, please explain (if hospitalized, please give physicians, hospital and date)

_____

Previous surgeries or procedures (please give surgeon, hospital and date): _____

_____

Have you recently had any of these symptoms?

	YES	NO
34. Blurring of vision, double vision, yellow halos around lights?		
35. Hearing loss or ringing in ears?		
36. Frequent nose bleeds?		
37. Blood in stools or on toilet paper?		
38. Pain in legs or hips with walking?		
39. Swollen legs in evening or upon rising in morning?		
40. Persistant hoarseness or change in voice?		
41. Dizziness or lightheadedness		
42. Constipation or irregular BM		
43. Persistant cough?		
44. Chest pains and/or shortness of breath (circle response)		
45. Numbness or weakness in arms, hands, fingers, legs, feet, or toes?		
46. Weight gain or loss? (circle)		
47. "Night cough" or "night sweats" (circle response)		
48. Enlarged lymphnodes or tender lymphnodes		
49. Painful or difficulty urinating		
50. Frequent urination or nocturia		

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If the answer to any of the items at the bottom of the reverse sise is yes, please explain: _____

_____

Family History:

Does any family member or relative have any of the following?

	YES	NO
1. Diabetes Mellitus	_____	_____
2. High Blood Pressure	_____	_____
3. Heart Disease or problems	_____	_____
4. Lung Disease or problems	_____	_____
5. Strokes	_____	_____
6. Seizures, fits, convulsions	_____	_____
7. Blood disorders eg. Anemia	_____	_____
8. Kidney disease or problem	_____	_____
9. Mental disorders eg. Psychosis	_____	_____
10. Genetic disorders ("born with")	_____	_____
11. Bone disease	_____	_____
12. Cancer or Tumors	_____	_____

	YES	NO	If YES, Give Year
1. Tetanus	_____	_____	_____
2. Pneumonia	_____	_____	_____
3. Influenza	_____	_____	_____
4. Measles	_____	_____	_____
5. Mumps	_____	_____	_____
6. Rubella	_____	_____	_____
7. Hepatitis	_____	_____	_____

If the answer to any of the above questions is yes, please explain: _____

_____

FEMALE PATIENTS ONLY:

How many pregnancies? _____ Live births? _____ Abortions or Miscarriages? _____ C-sections? _____

Are you pregnant? _____ YES _____ NO Last menstruation date _____/_____/_____

Previous hysterectomy?: Complete _____ Partial _____ Ovaries removed?: _____ YES _____ NO

Present contraception method: Birth control pills _____ Norplant _____ Diaphragm _____ IUD _____ Condom
Spermicide (vaginal foam) _____ None _____

Complications from any of the above birth control methods: _____ YES _____ NO IF yes, explain: _____

How old were you when your periods started? _____ Age of menopause: _____

GYN Infections (eg.: uterus, cervix, ovaries) or vaginal infections? _____

_____

SCREENING TESTS:

	DATE	NORMAL	ABNORMAL	If abnormal, please explain
1. Pap	_____	_____	_____	_____
2. Breast Exam	_____	_____	_____	_____
3. Mammogram	_____	_____	_____	_____
4. Rectal Exam or Stool Blood Test	_____	_____	_____	_____
5. Sigmoidoscopy or Colonoscopy	_____	_____	_____	_____
6. Eye Exam	_____	_____	_____	_____