EMMANUEL CHRISTIAN HEALTH CENTER PROBLEM-FOCUSED MEDICAL HISTORY rev 11/2010

First Name_______________ Last Name____________________ Date of Birth ______________ Today's date _______________

Reason for visit: Explain the one specific problem you need us to address today____

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MEDICATION: Please give us a list of all prescription and over-the-counter medicines you are taking. Include medicine name, strength and how often you take it (example: *lipitor 40 mg every night*). **If you do not have a list, then bring all your medicine containers when you come for your visit. BE SURE TO ASK FOR ANY REFILLS YOU NEED WHILE YOU ARE BEING SEEN TODAY. WE DO NOT ACCEPT REFILL REQUESTS BY PHONE.**

PAST ILLNESS: Indicate if you have or ever had: high blood pressure ☐ diabetes ☐ high cholesterol ☐ arthritis ☐ asthma ☐ emphysema ☐ angina ☐ blocked arteries in heart ☐ heart attack ☐ , when?__________ stroke ☐ , when? ___________ atrial fibrillation ☐ cancer ☐ , what kind(s)? ______________________ underactive thyroid ☐ other major illness ______________________

ALLERGIES: Please indicate if you have been allergic to or had a bad reaction to the following: no allergies ☐ penicillin ☐ sulfa ☐ codeine ☐ aspirin ☐ iodine ☐ latex (rubber) ☐ flu shots ☐ other allergies ______________________

TOBACCO USE: Please indicate if you never smoked ☐ smoke ☐ _________ Packs a day have quit smoking ☐ when? ___________

ALCOHOL USE: non-drinker ☐ on rare occasion ☐ socially ☐ 2 drinks or less per day ☐ other amount ______________

SURGERIES: Please indicate if you have had hysterectomy ☐ both ovaries out ☐ appendix out ☐ tonsils out ☐ gallbladder out ☐ open heart for bypass ☐ when? _______________ other operations ______________________

FAMILY HISTORY: Please check if your mother, father, sisters, brothers or children have had: heart attack ☐ diabetes ☐ asthma ☐ high blood pressure ☐ high cholesterol ☐ thyroid disease ☐ hardening of the arteries ☐ severe arthritis ☐ stroke ☐ cancer ☐ (what kinds?) ______________________ other major illness______________________

SOCIAL HISTORY: married ☐ single ☐ widowed ☐ divorced ☐ retired ☐ employed ☐ line of work ______________

REVIEW OF SYSTEMS: Please answer the following questions and indicate if you have recently had any of the following symptoms. If you have other symptoms not relating to your main problem or which require less urgent attention we can schedule you to return to address these in the near future.

GENERAL: fever ☐ chills ☐ poor appetite ☐ tiredness ☐ weight loss without trying ☐ weight gain ☐ heavy sweating ☐

HEAD/EYE/ EAR/NOSE/ THROAT: frequent headaches ☐ eye pain ☐ vision problems ☐ earache ☐ hearing loss ☐ sinus problems ☐ runny or stuffy nose ☐ frequent sore throats ☐ hoarseness ☐ other ______________________

LUNGS: short of breath at rest ☐ short of breath with exercise ☐ chest hurts when taking a deep breath ☐ wheeze ☐ dry cough ☐ cough up blood ☐ cough up mucus ☐ if so, what color? ______________ loud snoring ☐ other ______________________

HEART/CIRCULATION: chest pain, pressure, or tightness ☐ short of breath when lying flat ☐ swelling of ankles ☐ heart murmur ☐ dizzy spells ☐ palpitations (fluttering or racing of heart) ☐ calf of leg hurts when walking ☐ fainting spell ☐ when? ______________

INTESTINES: nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ pain in the stomach area ☐ heartburn ☐ indigestion ☐ blood in bowel movements ☐ black bowel movements ☐ trouble swallowing ☐ What year was your last Colonoscopy? ____________

URINARY TRACT: pain or burning with urination ☐ blood in the urine ☐ loss of bladder control ☐ have to strain to pass urine ☐ get up at night to urinate ☐ 1-2 times ☐ 3 or more times ☐ loss of sexual ability ☐ **MEN ONLY:** lump in testicle ☐ discharge from penis ☐

NERVOUS SYSTEM/EMOTIONAL: numbness or tingling ☐ temporary loss of vision ☐ double vision ☐ memory loss ☐ nervousness ☐ weakness of arm or leg ☐ slurring or loss of speech ☐ feel depressed ☐ trouble sleeping ☐ mood swings ☐ lack of sexual desire ☐

ENDOCRINE: excessive thirst ☐ dry mouth ☐ urinate excessively large amounts ☐ unusually sensitive to cold or heat ☐

PREVENTIVE: What year was your last: pneumonia shot _______ flu shot________ shingles vaccine_______ tetanus shot________ EKG________

LADIES ONLY: discharge from vagina ☐ vaginal dryness ☐ hot flashes ☐ heavy periods ☐ When was you last period? ___________ Date of last mammogram _______________ Date of last pap smear ______________ Date of last scan for osteoporosis ____________