## MEDICAL HISTORY AND SCREENING FORM

The purpose of preventive exams is to screen for potential health problems and provide education to promote optimal health. It is best practice for chronic health problems to be addressed by your community primary care provider. In keeping with these standards and to promote continuity of care, Sindecuse clinicians will not be providing evaluation or treatment for chronic conditions during preventive exams. Please complete the information below prior to the arriving for registration. Preventive exams will be rescheduled for patients without completed Medical History and Screening Forms.

General Info	rmation		
Name			
Address			
Contact phone numl	bers		
Birth date			
Family Physician	and/or Primary Health (	'are Provider	
	•		
		•	
A copy of your visit/	labs will be sent to your physi	cian or primary health care	provider.
Past Medical	l History		
	tions to which you answe o you have any of the foll		ank) & comment below. Have
	Substance Abuse:		Neuro
_	Alcohol	_	Migraine
0	Marijuana	0	2: 1
0	Other drugs	0	Seizure
	Bleeding tendency	0	Other
	Breast disease		GI
	Cancer	0	Jaundice
0	Breast	0	Liver disease
0	Uterine	0	Gallbladder disease
0	Other	0	Gastritis/Ulcer disease
	Psychiatry	0	Acid reflux
0	Depression	0	
0	Anxiety	0	Other
0	Bipolar		Kidney
0	Eating disorder	0	Kidney infection
	Diabetes	0	Bladder infection
	High cholesterol	0	,
	Cardiac		Thyroid disorder
0	Heart murmur		Varicose veins
0	Heart attack		Seizure disorder
0	High blood pressure		Lung
	Hepatitis	0	Sleep apnea
	Glaucoma	0	Asthma
	Dental disease		

0 0	Chronic Obstructive Pulmonary Disease Tuberculosis Seasonal allergies		Blood clots Serious trauma Sexually transmitted infection Other
。 □	Other Environmental allergies		
_	· ·		
Comments: _			
SYMPTOMS			
	ently having or have you recently ha as to which you answer yes (leave th		
	Fevers		Abdominal pain
	Night sweats	0	Nausea
	Unexplained weight loss/gain	0	Vomiting
	Fatigue	0	Diarrhea
	Headaches		Rectal pain
	Vision problems	0	Change in bowel habits
	Hearing problems	0	Blood in stool
	Dizziness	°	Black stool
	Ringing in ears		Muscle, bone or joint pain
	Eye pain		Leg cramps
	Ear pain		Skin color changes
	Nosebleeds		Persistent bruising
	Sore throat		Inability to sleep flat
	Difficulty swallowing		Change in size/color of mole
	Hoarse voice		Numbness of extremities
	Persistent cough		Muscle weakness
	Coughing up blood		Tremor
	Chest pain		Urinary symptoms Blood in urine
	Palpitations/irregular	0	More frequent urination
	heartbeat	0	Incontinence/loss of urine
	Swelling of extremities	0	Pain
	Shortness of breath		Sexual dysfunction
	Lightheadedness		Mood changes
	Change in appetite		Difficulty sleeping
Comments: _			

Type of surgery and specific date or your age at surgery:    HOSPITALIZATIONS:   List hospitalizations, including dates of and reasons for hospitalization:	SURGERIES:					
List hospitalizations, including dates of and reasons for hospitalization:    MEDICATIONS:	Type of surgery and specific date or your age at surgery:					
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MEDICATIONS:  List any prescription medications (with dosage and frequency of use) you are now taking:  List any self-prescribed medications, dietary supplements, or vitamins (with dosage and frequency of use) you are now taking:  ALLERGIES:  List any drug or medical materials (latex) allergies and reaction:  Family History  Indicate illnesses in blood relative (i.e. parents, grandparents, siblings) - Check those questions to which you answer yes (leave the others blank).  Substance Abuse:  Alcohol  Marijuana  Mental illness  Drugs  Depression  Anemia  Bleeding or clotting abnormality  Parents  Breast disease  Grandparents  Caneer  Prostate  Skin  Colon  Lung Breast cancer  Other  Other  Other  Diabetes  Connective tissue disorder	HOSPITALIZA	ATIONS:				
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List any self-prescribed medications, dietary supplements, or vitamins (with dosage and frequency of use) you are now taking:    ALLERGIES:	MEDICATION	S:				
List any self-prescribed medications, dietary supplements, or vitamins (with dosage and frequency of use) you are now taking:    ALLERGIES:	List any prescrip	otion medications (with do	sage and frequency of use) vo	บ ล	re now taking:	
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☐ Diabetes ☐ Connective tissue disorder				0	Osteoarthritis	
Diabetes	_				Connective tissue disorder	
☐ Heart disease ○ Lupus	_			0	Lupus	

## o Scleroderma

□One □Multiple

## Health and Lifestyle Do you smoke? ☐ Yes □ No If you smoke, how many per day? \_\_\_\_\_ Age started Are you concerned about your own or someone else's alcohol abuse? Yes No □No Have you ever felt you should cut down on your drinking? $\square$ Yes Have people annoyed you by criticizing your drinking? □Yes $\square$ No □No Have you ever felt bad or guilty about your drinking? $\square$ Yes Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? $\square$ Yes ☐ No Do you often having the feeling of being overwhelmed or depressed? $\square$ Yes □No Do you exercise? $\square$ Yes $\square$ No If yes, type of exercise: If yes, frequency of exercise: Do you use a seatbelt at least 90% of the time? $\square$ Yes $\square$ No Immunization Update: Check box if yes and put date received. Tetanus: Date: \_\_\_\_\_ Measle, Mumps, Rubella: Date: Date: Flu Shot: $\square$ Varicella (chicken pox) vaccine: ☐ Date: \_\_\_\_\_ Pneumovax (pneumonia) vaccine: □ Date: Zoster (shingles) vaccine: Date: \_\_\_\_\_ **Sexual History** Have you ever been sexually active? $\square$ Yes $\square$ No Are you currently sexually active? $\square$ Yes $\square$ No Complete the following questions if you are sexually active. Are you currently having sexual relations with one partner or multiple partners?

Number of partners in last year:						
Are you in a monogamous relationship? □Yes □No						
Are/Is your sexual partner(s): ☐Men ☐Women ☐Both						
Do you and your partner use contraceptive and/or protective methods? $\square$ Yes $\square$ No						
Have you ever had a sexually transmitted illness (STI) (i.e. HPV, Herpes, Chlamydia, Gonorrhea or other)? $\square$ Yes $\square$ No						
List STI: Treated:  \Box Yes \Box No						
Gynecologic History						
Do you have a period every month? □Yes □No						
Number of days of flow:						
Menstrual cramps: □Mild □Moderate □Severe □None						
Date of last PAP smear: Last PAP smear result:						
Have you ever had an abnormal PAP smears? □Yes □No						
If yes, explain clinical history (including test location, date, what was done) for any abnormal PAP smear:						
Number of pregnancies:						
Are you presently trying to become pregnant or will be trying soon? □Yes □No						
Gynecologic symptoms: Check those questions to which you answer yes (leave the others blank).						
☐ Abnormal menstrual bleeding ☐ History of prescription						
☐ Missed periods hormone use						
☐ Night sweats ☐ Mood changes associated with						
Hot flashes						
□ Vaginal dryness □ Insomnia						
Have you ever had a mammogram? □Yes □No						
If applicable, indicate the date and result of your last mammogram:						