Stafford HealthCare Clinics
Established 1980
Walk In Clinic ◆ Occupational Medicine ◆ SEDA

PATIENT HISTORY

FORM010101©

Welcome to Stafford HealthCare Clinics. As a new patient, please fill out the information below to the best of your ability.

Patient Name:_____ Birthdate:_____ Date:_____
(Please Print) (MM/DD/YY) (Today's Date)

Have you ever had the following: Circle "No" or "Yes", leave blank if unsure.

Past Medical History

Measles	No	Yes	Back Trouble/Pain/Surgery	No	Yes	Bladder Infection	No	Yes
Mumps	No	Yes	Diabetes	No	Yes	Kidney Disease	No	Yes
Chickenpox	No	Yes	Thyroid Disease	No	Yes	AIDS or HIV+	No	Yes
Whooping Cough	No	Yes	High Blood Pressure	No	Yes	Venereal Disease	No	Yes
Scarlet Fever	No	Yes	Low Blood Pressure	No	Yes	Hepatitis	No	Yes
Diphtheria	No	Yes	Mitral Valve Prolapse	No	Yes	Ulcer	No	Yes
Smallpox	No	Yes	Stroke	No	Yes	Hernia	No	Yes
Polio	No	Yes	Rheumatic Fever	No	Yes	Hemorrhoids	No	Yes
Pneumonia	No	Yes	Heart Disease	No	Yes	Anemia / Sickle Cell	No	Yes
Tuberculosis	No	Yes	Glaucoma	No	Yes	Bleeding Tendency	No	Yes
Asthma	No	Yes	Epilepsy (seizures)	No	Yes	Blood/Plasma Transfusion	No	Yes
Infectious Mono	No	Yes	Migraine Headaches	No	Yes	Medication Allergies	No	Yes
Bronchitis	No	Yes	Cancer	No	Yes	Please list any known medication allergies:		
Arthritis	No	Yes	Hives or Eczema	No	Yes	_____		
Are All Childhood / Adult Immunizations Current and Up To Date - -				No	Yes	_____		

Please Check Yes and *CIRCLE* any previous Surgeries / Injuries or Hospitalizations, List Any Others .

Past Surgical History

✓ Yes	Surgery / Injury / Illness	Date	Doctor
	Appendectomy		
	Tonsillectomy, Adnoidectomy, Tubes in Ears		
	Hysterectomy, Tubal ligation		
	C - Section, Normal Delivery		
	Angioplasty, Heart By Pass		
	Neck, Back, Shoulder, Elbow *INJURY / SURGERY*		
	Wrist, Hip, Knee, Ankle *INJURY / SURGERY*		
	Hand, Foot, Finger(s), Toe(s) *INJURY / SURGERY*		

Health Maintenance

Females: Please list year of last:

Mammogram_____ EKG _____
Pap Smear_____ Blood in Stool Test _____
Blood Test_____ Tetanus Shot_____

Males: Please list year of last:

EKG _____ PSA_____
Blood in Stool Test_____ Blood Test_____
Tetanus Shot_____

Family History

Relative	Living	Age(s)	Diseases	Deceased	Age at Death	Cause of Death
Father						
Mother						
Siblings (male)						
(female)						
Spouse						
Children (male)						
(female)						

Is there any OTHER family history (Aunts, Uncles, Grandparents) of the following: Circle "Yes" or "NO", leave blank if unsure. Fill in additional

Seizures	NO	YES		Kidney Disease	NO	YES		Cancer	NO	YES
Alcoholism	NO	YES		Heart Disease	NO	YES		High Blood Pressure	NO	YES
Tuberculosis	NO	YES		Diabetes	NO	YES		Drug Use	NO	YES
Strokes	NO	YES		Psychiatric Disorder	NO	YES				
Other:										

Medications

Please list any medications and dosage you are currently taking (prescription and non-prescription):

NAME *Example: Aspirin*	DOSAGE *325 mg*	FREQUENCY *Once a day*	DOCTOR -

Social History

Marital Status: Single:_____ Married:_____ Separated:_____ Divorced:_____ Widowed:_____

Use of Alcohol: Never:_____ Rarely:_____ Socially:_____ Daily:_____

Use of Tobacco: Never:_____ Previously, but quit _____ Current packs per day:_____

Use of Caffeine: Rarely:_____ Daily:_____ Amount (cups): 1 2 3 4 More

Exercise: Rarely:_____ Daily:_____ 3 or More Times a Week: _____

Education: Highest Grade Level Completed:_____

Occupation: _____ Military Service: _____