OKEENE HOSPITAL MEDICAL CLINIC **PATIENT HISTORY** (Please Print) MR # (Office Use) _____

Name:_____ Sex: ❑M ❑F Age _____ DOB _____

FOOD & MEDICAL ALLERGIES ❑ NONE ❑ YES—IF YOU HAVE ALLERGIES, PLEASE LIST THE TYPE OF REACTION.

List: _____

Past Medical History: Please ✓ below under the "yes" column or "no" column to indicate any problems you have had in the past year.

GENERAL

YES	NO	
❑	❑	Skin Rash
❑	❑	Weakness
❑	❑	No Appetite
❑	❑	Chills/Sweats
❑	❑	Sleeping Difficulty
❑	❑	Prolonged Fever
❑	❑	Bleeds Easily

HEAD

YES	NO	
❑	❑	Frequent Headache
❑	❑	Migraines
❑	❑	Dizzy Spells
❑	❑	Fainting
❑	❑	Unconsciousness

EYES

YES	NO	
❑	❑	Wears Glasses
❑	❑	Major Vision Change
❑	❑	Blurred Vision
❑	❑	See Double
❑	❑	Eye Pain/Itching

EARS

YES	NO	
❑	❑	Trouble Hearing
❑	❑	Earache
❑	❑	Drainage
❑	❑	Noise in Ears

NOSE

YES	NO	
❑	❑	Congestion
❑	❑	Sneezing
❑	❑	Sinus Trouble
❑	❑	Hay Fever
❑	❑	Nose Bleeds

THROAT

YES	NO	
❑	❑	Sore Throat/Tongue
❑	❑	Hoarse
❑	❑	Dental Problems
❑	❑	Goiter
❑	❑	Thyroid Trouble
❑	❑	Neck Pain/Lumps

LUNGS & HEART

YES	NO	
❑	❑	Wheezing Spells
❑	❑	Asthma
❑	❑	Cough Up Phlegm
❑	❑	Pneumonia
❑	❑	Tuberculosis
❑	❑	Exposed to TB
❑	❑	Cough Up Blood
❑	❑	Rheumatic Fever
❑	❑	Palpitations
❑	❑	High Blood Pressure
❑	❑	Swollen Feet/Ankles
❑	❑	Chest Pain
❑	❑	Heart Attack
❑	❑	Heart Murmurs

GI

YES	NO	
❑	❑	Heartburn
❑	❑	Indigestion
❑	❑	Ulcers
❑	❑	Persistent Nausea
❑	❑	Vomiting
❑	❑	Vomiting Blood
❑	❑	Difficulty Swallowing
❑	❑	Stomach Pain
❑	❑	Constipation
❑	❑	Loose Stools
❑	❑	Change in Bowels
❑	❑	Black Stools
❑	❑	Bloody Stools

GU

YES	NO	
❑	❑	Frequent Urination
❑	❑	Difficulty Holding Urine
❑	❑	Difficulty Starting Urine
❑	❑	Painful Urination
❑	❑	Discharge
❑	❑	Kidney Stones

NERVOUS

YES	NO	
❑	❑	Epilepsy
❑	❑	Dizziness
❑	❑	Stroke
❑	❑	Paralysis
❑	❑	Can't Make Decisions
❑	❑	Memory Problems
❑	❑	Depressed/Feel Sad
❑	❑	Considered Suicide
❑	❑	Lost Consciousness
❑	❑	Excessive Fear

BONES

YES	NO	
❑	❑	Aching Joints
❑	❑	Aching Muscles
❑	❑	Leg Cramps
❑	❑	Leg Pain
❑	❑	Painful Feet
❑	❑	Polio
❑	❑	Pain in Arms
❑	❑	Numbness Arms/Legs

OTHER

YES	NO	
❑	❑	High Cholesterol
❑	❑	Diabetes
❑	❑	Excessive Thirst
❑	❑	Cancer
		Site: _____

HEALTH SCREENS

Please show the year of your last health test

Mammogram _____

Pelvic / Pap Smear _____

Bone Density _____

PSA (men only) _____

Colonoscopy _____

OPERATIONS

Operations (show year): ❑ None
- ❑ Tonsils
- ❑ Appendix
- ❑ Gallbladder
- ❑ Hernia
- ❑ Abdomen
- ❑ Heart
- ❑ Lungs
- ❑ Breast
- ❑ Female organs
- ❑ Other: _____

OB HX

OB/GYN History

# of Pregnancies _____

Live Births _____

Abortions _____

Date of last Menstral Period _____

FAMILY HX

Has anyone in your immediate family had any of the following:

YES	NO	
❑	❑	Diabetes
❑	❑	High Blood Pressure
❑	❑	Heart Attack
❑	❑	Stroke
❑	❑	Cancer
		Site _____
❑	❑	Mental Illness
❑	❑	Suicide

FALL&ASSIST

Do you use or have installed any of these devices or equipment?

YES	NO	
❑	❑	Quad Cane
❑	❑	Walker
❑	❑	Wheelchair
❑	❑	Shower Bars
❑	❑	Raised Toilets

IMM

Please list the date of your last immunization(s):

Tetanus _____

Pneumonia _____

Other _____

LIFE STYLE

Usual Weight _____lb
Weight change in past year:
Gained _____lb Lost _____lb
# of Meals eaten daily?_____

Do you exercise?
❑ No ❑ Yes (list type)
_____

Tobacco: (check all that apply)
❑ Dip / Chew ❑ Cigars ❑ Cigarettes
Packs per day _____
# of Years _____
Years Stopped _____
Caffeine: ❑ Cups per day _____
Alcohol: ❑ Never ❑ Occasional
❑ Moderate ❑ Heavy

Have you ever used illegal or street drugs?
❑ No ❑ Yes (list type)
_____

Are you sexually active? ❑ No ❑ Yes
Have you ever been sexually active?
❑ No ❑ Yes

ED

Education Completed
- ❑ Grade
- ❑ High
- ❑ Business / Vocational
- ❑ College

OCCUP

Occupation
- ❑ Retired
- ❑ Title & Description

_____
_____

MARITAL

Marital Status
- ❑ Single
- ❑ Separated
- ❑ Divorced
- ❑ Widowed
- ❑ Married
- ❑ Significant Other

PATIENT SIGNATURE: _____

Date _____

Office Use Only

_____
_____
_____
_____
_____
_____
_____
_____
_____

PHYSICIAN SIGNATURE _____

DATE _____