EMMANUEL CHRISTIAN HEALTH CENTER MEDICAL HISTORY E mail: msmith@doctor-viv.com or Fax:(352) 259-5540
rev. 11/26/12

First Name_____ Last Name_____ Date of Birth _____ Today's date _____

If you prefer you may enter most of this requested information directly into your electronic record. Contact our office to receive your password.
Reason for visit_____

MEDICATION LIST: Please give us a list of all prescription and over-the-counter medicines you take, or enter them online into your electronic record. Include the medication strength and how often you take it. If you do not have a list, please bring all your medicines when you come for your visit. BE SURE TO ASK FOR ALL REFILLS YOU NEED AT THE TIME OF YOUR VISIT. YOU MAY ALSO REQUEST REFILLS ONLINE THROUGH YOUR ELECTRONIC RECORDS, OR HAVE YOUR PHARMACY SEND US A FAX. WE DO NOT ACCEPT REFILL REQUESTS BY PHONE.

PAST ILLNESS: Indicate if you have or ever had: high blood pressure ☐ (401.1) diabetes ☐ (250.0x) high cholesterol ☐ (272.x) osteoarthritis ☐ (715.00) asthma ☐ (493.90)

COPD ☐ (496) angina ☐ (413.9) blocked arteries in heart ☐ (414.01) heart attack ☐ (412), when?_____ stroke ☐ (434.91, v12.54), when? _____ atrial fibrillation ☐ (427.31)

cancer ☐, what kind(s)? _____ underactive thyroid ☐ (244.9) osteoporosis ☐ (733.90) 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 ☐ occasional ☐ light ☐ social ☐ more than 2 drinks per day ☐ beer ☐ wine ☐ hard liquor ☐

SURGERIES: Please indicate if you have had hysterectomy ☐ both ovaries out ☐ appendix out ☐ tonsils out ☐ gallbladder out ☐

prostate 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/ frequent headaches ☐ eye pain ☐ vision problems ☐ earache ☐ hearing loss ☐ sinus problems ☐
EAR/NOSE/
THROAT: 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 _____