EFFINGHAM PromptCare Primary & Urgent Care

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HEALTH HISTORY FORM

Today's date:

Reason for today's visit:

MEDICAL HISTORY

Medical History: Have you ever had any of the following? *(Check all that apply)*

- ☐ NONE of the problems listed
- ☐ Anemia
- ☐ Anesthetic reaction
- ☐ Anxiety
- ☐ Asthma
- ☐ Arthritis conditions
- ☐ Bleeding disorder
- ☐ BPH
- ☐ Coronary artery disease
- ☐ Cancer
- ☐ Celiac disease
- ☐ Chronic sinusitis
- ☐ Clotting disorder
- ☐ Congestive heart failure (CHF)
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/alcohol abuse
- ☐ Erectile dysfunction
- ☐ Family history of cancer
- ☐ Family history of diabetes
- ☐ Family history of heart disease
- ☐ Fibromyalgia
- ☐ Gerd
- ☐ Gout
- ☐ Heart disease
- ☐ Hormone imbalance
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Insomnia
- ☐ Irritable bowel syndrome
- ☐ Kidney problems
- ☐ Low testosterone
- ☐ Menopause
- ☐ Migraines/headaches
- ☐ Multisystem disorders
- ☐ Neuropathy
- ☐ Obesity
- ☐ Obstructive sleep apnea
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Seizure disorders
- ☐ Skin disorders
- ☐ Sinus conditions
- ☐ Stroke
- ☐ Thyroid disorders
- ☐ Vitamin deficiency
- ☐ Other not listed

Did you mark other not listed?

☐ Yes ☐ No

If yes, please list conditions here:

ALLERGIES & MEDICATIONS

Do you have allergies?

☐ Yes ☐ No

If yes, list all known allergies:

List all medications you are currently taking (also include any OTC medications, vitamins, and supplements):

Medication Name:	Medication Dosage:	Prescribing Doctor:

Phone: (217) 347-0768 401 N. Mulberry St., Effingham, IL 62401 Fax: (217) 347-0729

HEALTH HISTORY FORM

SURGICAL HISTORY

Surgical History: Please list any/all surgeries:

Type of Surgery:	Date of Surgery:	Surgeon/Location:

FAMILY HISTORY

Please indicate if any of your relatives have had any of the following by placing an X in the appropriate box.

Cancer: ☐ Maternal ☐ Paternal **Notes:**

Diabetes: ☐ Maternal ☐ Paternal **Notes:**

Heart Problems: ☐ Maternal ☐ Paternal **Notes:**

Hypertension: ☐ Maternal ☐ Paternal **Notes:**

Stroke: ☐ Maternal ☐ Paternal **Notes:**

Other: ☐ Maternal ☐ Paternal **Notes:**

Other: ☐ Maternal ☐ Paternal **Notes:**

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HEALTH HISTORY FORM

SOCIAL HISTORY

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ Weekly ☐ Infrequently ☐ Recovering Alcoholic

Do you use tobacco? ☐ Yes ☐ No

If yes, what form of tobacco do you use? ☐ Smoke ☐ How many packs per day? ☐ Chew

Do you use recreational drugs? ☐ Yes ☐ No

If yes, please list drugs:

PROVIDERS

List all providers/specialists you see including dental and vision:

Provider Name & Location:	Specialty:

SIGNATURES

Signature of Responsible Party: _____ **Date:** _____

Printed Name of Responsible Party: _____

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