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AMC URGENT CARE PLUS
Minor Emergency & Occupational Medicine Center

DATABASE TOOL
Medical and Personal History

Patient Name:_____ Date:_____
DOB:_____ Sex: M / F Race:_____

For what reason are you here today? _____

Please check conditions which you have had?

GENERAL
- ☐ Serious Infections (e.g. pneumonia)_____
- ☐ Diabetes Mellitus
- ☐ Rheumatic Fever
- ☐ HIV Infection
- ☐ Cancer (where?)_____

CVS
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Angina
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Abnormal Heart Rhythm
- ☐ Blood Clots in Veins
- ☐ Blocked Arteries in Neck
- ☐ Blocked Arteries in Legs

HEENT
- ☐ Glaucoma
- ☐ Allergies "hay fever"
- ☐ Frequent Ear Infections
- ☐ Frequent Sinus Infections

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ Blood Clots in Lungs
- ☐ Sleep Apnea

MUSCULOSKELETAL / EXTREMITIES
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Joint Disease
- ☐ Fibromyalgia
- ☐ Neck Pain (herniated disc)
- ☐ Back Pain (herniated disc)

LYMPHATIC / HEMATOLOGIC
- ☐ Thyroid Goiter
- ☐ Over Active Thyroid
- ☐ Under Active Thyroid
- ☐ Transfusions
- ☐ Anemia

GI / GU
- ☐ Stomach Ulcers
- ☐ Ulcerative Colitis
- ☐ Crohns Disease
- ☐ Bleeding from Intestines
- ☐ Diverticulitis
- ☐ Colon Polyps
- ☐ Irritable Bowel Disease
- ☐ Hepatitis
- ☐ Cirrhosis of the Liver
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Gallstones

- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Disease
- ☐ Endometriosis
- ☐ Sex Transmitted Infection

SKIN / BREAST
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Fibrocystic Breast Disease

NEUROLOGIC / PSYCHIATRIC
- ☐ Chronic Vertigo (Meniere's)
- ☐ Peripheral Nerve Disease
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Depression
- ☐ Anxiety

Doctor's Notes: _____

Please indicate any surgeries you have had and the year you had them.

Year
- ____Angioplasty
- ____Carotid Artery Surgery
- ____Other Vascular Surgery
- ____Coronary Bypass Surgery
- ____Chest / Lung Surgery
- ____Tonsillectomy
- ____Neurosurgey

Year
- ____Trauma Related Surgery
- ____Back or Neck Surgery
- ____Hip Surgery
- ____Knee Surgery
- ____Carpal Tunnel Surgery
- ____Sinus Surgery
- ____Ear Surgery

Year
- ____Stomach Surgery
- ____Inguinal Hernia
- ____Colonoscopy
- ____Gallbladder
- ____Appendectomy
- ____Prostate Surgery
- ____Bladder Surgery

Year
- ____Tubal Ligation
- ____C-Section
- ____Hysterectomy
- ____Ovary Removed
- ____Breast Surgery
- ____Thyroid Surgery
- ____other_____

Doctor's Notes: _____

Please indicate when you last had any of the following preventative tests or services.

Year
- ____Cardiac Angiogram
- ____Stress Test
- ____Echocardiogram
- ____Chest X-ray
- ____EKG

Year
- ____Flu Vaccine
- ____Pneumonia Vaccine
- ____Tetanus Vaccine
- ____Hepatitis Vaccine
- ____Bone Density Test

Year
- ____Prostate Cancer Blood Test
- ____Rectal Exam
- ____Colon Cancer Stool Test
- ____Flexible Sigmoidoscopy
- ____Barium Enema

Year
- ____Mammogram / Breast Exam
- ____Pap Smear
- ____Date of Last Physical Exam
- ____other_____

Doctor's Notes: _____

PATIENT FORM

Please list any allergies or intolerance to drugs or other substances.

Please list the medications currently taken, their dosages, and how many times per day you take them.

FAMILY MEDICAL HISTORY

Please check or list any major illness in your family members. (Mother, Father, Brothers, Sisters, or Children)

- ☐ Tuberculosis
- ☐ Emphysema
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Diabetes Mellitus
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Hemophilia
- ☐ _____
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Neurological Disorder
- ☐ Liver Disease
- ☐ _____
- ☐ Breast Cancer
- ☐ Ovarian Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ _____

Notes:

PERSONAL INFORMATION

Please write in or circle the information that applies to you:

Occupation:

Education	Sexuality	Marital Status	Living Status	Diet	Exercise	Alternative Medicine
primary	heterosexual	single	alone	none	none	holistic
secondary	homosexual	married	with spouse	low fat	walking	chiropractic
college	bisexual	divorced	with parents	low chol	aerobics	homeopathy
post grad	transsexual	widowed	assisted living	low carbo	weightlifting	acupuncture
doctorate		separated	nursing home	vegetarian	___days / wk	herbal

Tobacco
never / past / active
cigarette / cigar / pipe
snuff / dip / chewing
Start_____ Stop_____
packs per day _____

Alcohol
never / past / active
liquor / wine / beer
___drinks per
day / week / month
AA / Alcohol Rehab

Illicit Drugs
never / past / active
cocaine / marijuana
heroin / amphetamine
barbiturate / LSD / PCP
IV Drug Abuse / Drug Rehab

Caffeine
never / past / active
coffee / tea / soda
_____cans / cups per day

Doctor's Notes: