KADLEC CLINIC

Patient History

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last name: First name: Age: Sex: M F Date of Birth
Pediatric Patient Information: Mother's Name _____ Father's Name _____ Parents' Marital Status: Married Single Divorced Sibling(s) (name and DOB): _____ Child lives with: Mother Father Both Please list other people who live in your household: _____ School/Grade: _____ Delivery Hospital:_____ Birth Weight:_____ Gestational Age at Delivery: _____ Type of Delivery: Vaginal C-Section reason:_____ Any problems with pregnancy: _____ Any problems with delivery: _____

Who referred you to us for our services?

□ Self □ Primary Care Provider □ Family
□ Neighbor/friend □ The court

Presenting problem:

Reason for today's visit?

Describe the two primary reasons that you are here today:

	Reason 1	Reason 2
Explanation		
Date symptoms first occurred		
Frequency of symptoms		
What makes conditions improve?		
What makes conditions worse?		
Previous treatment		
Practioner who provided treatment	**Name:** **Phone:**	**Name:** **Phone:**

If you have additional issues to discuss, please describe briefly:

Have you ever had a **blood transfusion**? □ Yes □ No If yes, when _____

FEMALES ONLY: Are you pregnant? □ Yes □ No
Do you still have periods? □ Yes □ No
If yes, are they regular? □ Yes □ No
If No, How long ago without a period _____

ALLERGIES: Please list type and reaction

Drug	Reaction	Drug	Reaction

MEDICATIONS: Please list all drugs you take and their dosages (**PLEASE BRING ALL MEDICATION BOTTLES TO YOUR APPOINTMENT)**

Medication	Dosage	Medication	Dosage

Other Personal History:

List all major illnesses / hospitalizations (continue on reverse if necessary):

Illness / Hospitalization *Date(s)*

_____

_____

_____

List all injuries (continue on reverse if necessary):

Injuries *Date(s)*

_____

_____

_____

Are you up to date on vaccinations: Yes No

Last Tetanus: _____ Last Pneumonia: _____

Last Flu: _____ Last Pertussis (whooping cough): _____

Last Shingles Vaccine _____

List travel (outside of Washington State) in the past two years (continue on reverse if necessary):

Destination *Date(s)*

_____

_____

_____

Review of systems

Have you experienced any of the following in the last fourteen (14) days:

Y	N		Y	N	
		1. Constitutional			**8. Musculoskeletal**
		Recent fever			Frequent fractures or sprains
		Recent weight loss			History of arthritis
		Recent unwanted weight loss			**9. Integumentary**
		2. Eyes			Recent changes in skin
		Glaucoma			**10. Neurological**
		Recent changes in vision			History of frequent headaches
		3. Ears, Nose, Mouth, Throat			Seizures or convulsions
		Frequent ear infections			**11. Psychiatric**
		Frequent sore throats			Treatment for psychiatric problems
		Frequent sinus infections			Treatment for drug or alcohol dependency
		4. Cardiovascular			**12. Endocrine**
		Chest pains or discomfort in chest			Decreased energy
		Shortness of breath			Dizziness
		5. Respiratory (*circle those that apply*)			**13. Hematologic/Lymphatic**
		Asthma, bronchitis, pneumonia, pleurisy, TB			Easy bruising or bleeding
		6. Gastrointestinal			**14. Allergic/Immunologic**
		Frequent indigestion or heartburn			Severe allergic reactions to:
		Vomiting			Hay fever
		Passing bloody or black stools			**OTHER:** (list)
		7. Genito-Urinary			
		Blood in urine			
		Painful urination			

Family History:

If your family has a history of any of these conditions, please do the following:

a. Circle the condition

b. Write 'F' for father, 'M' for mother, or 'S' for sibling within the parentheses

( ) Heart disease	( ) Kidney problems	( ) Stroke
( ) Cancer	( ) High blood pressure	( ) Diabetes
( ) Obesity	( ) Depression	( ) Schizophrenia
( ) Early dementia	( ) Manic-depressive disorder	( ) Thyroid Disorder
( ) Seizure disorder	( ) Alcoholism	( ) Other (list below)

_____

_____

Social History:

Race:

□ Caucasian □ African-American □ Asian

□ Hispanic □ American Indian □ Other _____

Marital status:

□ Single □ Married (how long? _____)

□ Separated □ Divorced (how long? _____) □ Widowed

Children:

Girls _____ Boys _____

Habits:

Do you smoke or use tobacco products? Y N

If no, have you ever smoked? Y N (Year quit: _____)

Do you drink alcohol? Y N

If no, did you in the past? Y N

Are you currently sexually active? Y N

Have you had more than 5 sexual partners in your lifetime? Y N

Have you ever tested positive for a Sexual Transmitted Disease or Infection? Y N

How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? _____

_____

Signature of person completing the form: □ Patient □ Other _____