MARTINSVILLE URGENT CARE

1044 E CHURCH ST

MARTINSVILLE VA 24112

PLEASE ATTACH A COPY OF ALL MEDICAL RECORDS FROM PREVIOUS DOCTORS TO THIS APPLICATION

FULL NAME: ______________________________________ **DATE OF BIRTH:**________________________

ADDRESS: **PHONE NUMBER:** ______________________

____

____

Who would you prefer for your Primary Doctor?(circle one)

Frank Lauzau **Amber Patterson**

Sandra Robertson **Edee Boitnott**

LIST OF CURRENT/PREVIOUS DOCTORS AND THEIR PHONE NUMBERS:

____ ____

____ ____

____ ____

____ ____

ALLERGIES & REACTIONS: **SURGERIES & DATES:**

____ ____

____ ____

____ ____

____ ____

MEDICATIONS AND DOSAGE:

____ ____

____ ____

____ ____

____ ____

SOCIAL HISTORY:

DO YOU DRINK? __ IF YES, HOW OFTEN? ____

DO YOU SMOKE? __ IF YES, HOW MUCH? ____ HOW MANY YEARS? _____ IF QUIT, WHEN? _____

DO YOU CHEW TOBACCO? _____ IF YES, HOW MUCH? _____

DO YOU USE RECREATIONAL OR ILLEGAL DRUGS? _____

HAVE YOU WORKED WITH ASBESTOS OR HAZARDOUS MATERIALS? _____

DO YOU HAVE A LIVING WILL? _____

DO YOU HAVE A HEALTHCARE PROXY? _____ IF SO, WHO? ____

HEALTH MAINTENANCE:

LAST MENSTRUAL PERIOD: __________ LAST PAP SMEAR: __________ LAST MAMMOGRAM: __________

LAST COLONOSCOPY: __________ LAST PROSTATE SCREENING: __________ LAST BONE DENSITY SCAN: __________

IMMUNIZATIONS/DATES: PNEUMONIA: __________ FLU: __________ TDAP: __________

HEP A: __________ HEP B: __________

FAMILY HISTORY:

ARE YOU ADOPTED? _____

FAMILY MEMBERS	MEDICAL PROBLEMS	CAUSE OF DEATH IF DECEASED	AGE AT DEATH
MOTHER			
FATHER			
MATERNAL GRANDMOTHER			
MATERNAL GRANDFATHER			
PATERNAL GRANDMOTHER			
PATERNAL GRANDFATHER			
SIBLING			
SIBLING			
SIBLING			
CHILD			
CHILD			
CHILD			

PAST MEDICAL ILLNESSES (CHECK IF YOU HAVE HAD THE FOLLOWING):

__ ADDICTION

__ANEMIA

__ ANEURYSM

__ ANXIETY

__ ARTHRITIS

__ ASTHMA

__ BLOOD DISORDERS

__ BLOOD CLOT

__ BLOOD TRANSFUSION

__ CANCER (IF SO, WHAT TYPE ?) ____________________________

__ CROHN'S DISEASE

__ COPD/EMPHYSEMA

__ DEPRESSION

__ DIABETES

__ GLAUCOMA

__ GOUT

__ HAY FEVER

__ HEART DISEASE

__ HEART MURMUR

__ HEPATITIS (A, B, C)

__ HIGH CHOLESTEROL

__ HIV

__ HYPERTENSION

__ KIDNEY DISEASE

__ KIDNEY STONES

__LIVER DISEASE

__ SEIZURES

__ SEXUALLY TRANSMITTED DISEASE (IF SO, WHAT TYPE?) _______________________________

__ SICKLE CELL

__ SLEEP APNEA

__ STOMACH ULCER

__ STROKE

__ THYROID DISEASE

__ TB

__ POSITIVE TB SKIN TEST

__ ULCERATIVE COLITIS

ANY OTHER PAST ILLNESSES NOT LISTED
PREVIOUSLY?____
____

REVIEW OF CURRENT SYMPTOMS (PLEASE CHECK IF YOU ARE CURRENTLY OR IF YOU HAVE RECENTLY HAD THESE SYMPTOMS):

WEIGHT GAIN		BLOOD IN VOMIT	
WEIGHT LOSS		BLOOD IN STOOL	
NIGHT SWEATS		DIFFICULTY URINATING	
WEAKNESS		TROUBLE HOLDING URINE	
FATIGUE		FREQUENCY OF URINATION	
INSOMNIA		PENIS DISCHARGE	
HEARING CHANGES		VAGINAL DISCHARGE OR BLEEDING	
VISION CHANGES		NIPPLE DISCHARGE	
RUNNY NOSE		BREAST PAIN	
NOSE BLEEDS		BREAST LUMP	
FEVER		PAIN WITH INTERCOURSE	
BLOOD IN SPUTUM		FEELING TOO HOT	
SHORTNESS OF BREATH		FEELING TOO COLD	
PERSISTENT COUGH		DIZZINESS	
CHEST DISCOMFORT		HEADACHES	
PALPITATIONS		MEMORY LOSS	
FAINTING		NUMBNESS/ TINGLING	
CHANGE IN EXERCISE TOLERANCE		TREMOR	
DIFFICULTY SWALLOWING		MOOD SWINGS	
INDIGESTION/HEARTBURN		ANXIETY	
NAUSEA		DEPRESSION	
VOMITING		SKIN RASH	
CONSTIPATION		BACK PAIN	
DIARRHEA		LEG PAIN	
CHANGE IN BOWEL HABITS		LEG SWELLING	

ARE YOU EXPERIENCING ANY SYMPTOMS NOT MENTIONED ABOVE? IF SO, WHAT ARE THEY?

_______________________________________ _______________________________________

_______________________________________ _______________________________________

ANY CONCERNS YOU WOULD LIKE TO DISCUSS AT YOUR VISIT?

_______________________________________ _______________________________________

_______________________________________ _______________________________________

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(PATIENT SIGNATURE) **(DATE)**