## Your Doctor's Immediate Care

Date of Service_____ Name _____ DOB _____

List Current Pharmacy_____ Location _____

Today's Problem _____

**Work Related:** Yes/No Smoker: Yes/No Alcohol: Yes/No **Primary Care MD:** _____

**Current Symptoms:**

_____

_____

_____

_____

**Allergies:** _____

Females LMP: _____ Any Recent Foreign Travel: Yes/No

**Past Medical History:** (Circle what applies)

| | | | |
|---|---|---|---|
| Arthritis | Epilepsy | Phlebitis | Hepatitis |
| Asthma | Glaucoma | Pregnancy, Normal | Jaundice |
| Bleeding Problems | Heart Problems | Pregnancy, Abnormal | Liver Disease |
| Cancer _____ | Hypertension | Rectal Bleeding | Pancreatitis |
| Constipation | Rheumatic Fever | Stroke | Tarry, Black Stools |
| Diabetes | Kidney Disease | Tuberculosis | Ulcer(s) |
| Diarrhea | Neurological Problems | Difficulty Swallowing | Vomiting |
| Emphysema | Nervous Condition | Gallbladder Problems | Vomiting blood |

**Past Surgical History:** (Circle what applies and write in the year )

| | | | | | |
|---|---|---|---|---|---|
| Appendectomy | _____ | D&C | _____ | Spine | _____ |
| Tonsils/Adenoids | _____ | Hysterectomy | _____ | Thyroid | _____ |
| Gallbladder | _____ | Joint Replacement | _____ | Heart | _____ |
| Hernia | _____ | Colon/Stomach | _____ | | |
| Chest | _____ | Lung | _____ | | |

**Family History: Please check if there is family history and indicate which member is affected.**

- ○ Diabetes _____
- ○ Hypertension _____
- ○ Heart Disease _____
- ○ Mental Illness _____
- ○ Cancer _____
- ○ Unknown _____
- ○ Liver Disease _____
- ○ Colon/Rectal Disease _____
- ○ Stroke _____
- ○ Breast Cancer _____
- ○ Kidney Disease _____