1301 Huffman Rd.
Anchorage, AK 99515
345-1199

FIRST CARE
MEDICAL CENTERS, LLC

HEALTH HISTORY
(CONFIDENTIAL)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____ Who is your private physician? _____

SYMPTOMS Check (✓) symptoms you have **currently**.

GENERAL
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ❑ Arms ❑ Hips
- ❑ Back ❑ Legs
- ❑ Feet ❑ Neck
- ❑ Hands ❑ Shoulders

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

GASTROINTESTINAL
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Indigestion
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

CARDIOVASCULAR
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

EYE, EAR, NOSE, THROAT
- ❑ Bleeding gums
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Difficulty swallowing
- ❑ Double vision
- ❑ Earache
- ❑ Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Cough
- ❑ Ringing in ears
- ❑ Sinus problems
- ❑ Vision-Flashes
- ❑ Vision-Halos

SKIN
- ❑ Bruises easily
- ❑ Hives
- ❑ Itching
- ❑ Changes in moles
- ❑ Rash
- ❑ Scars
- ❑ Sores that won't heal

MEN only
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Other

WOMEN only
- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Other

First day of last menstrual period: _____
Date of last Pap Smear: _____
Date of last Mammogram: _____
Are you pregnant? _____
Breast feeding? _____
Number of pregnancies: _____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding Disorders
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Seizures
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease

MEDICATIONS List medications you are currently taking: ❑ None		**IMMUNIZATIONS:**	**ALLERGIES** To medications or substances: ❑ None
Prescription:	Non-Prescription Medication Herbs/Vitamins	Tetanus? ❑Yes ❑No Date:	List Any Reactions That Occured:
		Other:	
Pharmacy Name:	Phone:		*(Please Fill Out Back Page)*

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had and of the following: Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Stroke	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS AND/OR SURGERIES

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? ❑ Yes ❑ No

If yes, please give approximate dates. _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

Pregnancy History: Please state number of times

	Pregnancies
	Live Births
	Miscarriages
	Abortions

HEALTH HABITS:

Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Alcohol	
	Recreational Drugs	
	Diet	
	Exercise	

OCCUPATIONAL CONCERNS:

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ Signature

_____ Date

_____ Reviewed By

_____ Date