



SPARTANBURG COUNTY EMPLOYEE HEALTH CLINIC

Patient Medical History Form

(Please circle one) EMPLOYEE—SPOUSE—DEPENDENT—RETIREE

SS. #: _____ - _____ - _____

NAME _____ TODAY'S DATE _____ BIRTHDATE _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CELL: _____

SPOUSE OR PARENT NAME: _____

EMERGENCY CONTACT & (phone) _____

PHARMACY NAME & WHERE LOCATED: _____

JOB TITLE: _____ WORK#: _____

SUPERVISORS NAME: _____

History of Present Illness:

What medical problems do you have currently? (Why are you here?)

Which doctor(s) have been treating you?

Current Medications:

Please list all current prescribed medications with dosages: _____

Allergies to Medications:

Please list any medications that you have had allergic reactions to, and WHAT the reaction was:

- No known allergies
- Penicillin _____
- Sulfa _____
- Codeine _____
- Other (please list): _____

Risk Factors:

- Do you currently use any form of tobacco? Yes No How much? _____
- Are you exposed to cigarette smoke at home? Yes No
- Do you use alcohol? Yes No How much? _____
- Do you drink caffeine? Yes No How much? _____
- Do you exercise? Yes No How often? _____

Past Medical History:

Please list any chronic illnesses that you have had:

Family History:

Please list any family members (mother, father, brothers, sisters, and children) that have been treated for:

- | | | | |
|--|-------|---|-------|
| <input type="checkbox"/> High Blood Pressure | _____ | <input type="checkbox"/> Mental Illness | _____ |
| <input type="checkbox"/> Heart Attack | _____ | <input type="checkbox"/> Epilepsy | _____ |
| <input type="checkbox"/> Stroke | _____ | <input type="checkbox"/> Arthritis | _____ |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Gout | _____ |
| <input type="checkbox"/> Cancer (list type) | _____ | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Migraines | _____ | <input type="checkbox"/> Kidney Disease | _____ |
| <input type="checkbox"/> Glaucoma | _____ | <input type="checkbox"/> Allergies | _____ |
| <input type="checkbox"/> Other | _____ | | |

Social History:

- Do you have any children? Yes No If yes, how many? _____
- Marital Status: Single Married Separated Divorced
- Education: Elementary High School College Graduate Degree

Immunization History:

Please give approximate year of last immunization for:

- Tetanus (DPT) _____

Prevention: Has your cholesterol ever been checked? Yes No If yes, when? _____

Women Only:

What was the date of the start of your last menstrual period? _____

When was your last pap smear? _____

Have you ever had an abnormal pap smear? Yes No If yes, when? _____

Have you ever had a mammogram? Yes No If yes, when? _____

Men Only:

Have you ever had your PSA checked? Yes No If yes, when? _____

(PSA = Prostate Specific Antigen - a blood test)