

MANNING REGIONAL HEALTHCARE CLINIC

Updated and Reviewed:

Date _____
BY _____
Date _____
BY _____

321 Center Street, Manning, IA 51455

FULL NAME _____

Birth Date ____/____/____ Today's Date _____

Last First Middle Mo. Day Yr

MEDICATIONS:

Do you have any allergies or have you had any bad reactions to any medications? ___NO ___YES. If YES, Please List:

Please list all of the medications you are now taking INCLUDING non prescription medications:

Name of Medicine	Dose	How Long	Dr.'s name	Reason for taking the medication

IMMUNIZATIONS (Approx. date of last injection)	Date	Do you now or have you in the past:	How Much/
			No Yes How Long
Tetanus	_____	Chewed tobacco, smoked pipe or cigars	___ ___ ___
MMR (Measles/Mumps/Rubella)	_____	Smoked Cigarettes	___ ___ ___
If born after 1957, have you had a Rubella Titer or 2nd MMR?	YES ___ NO ___	Drank Coffee, tea or caffeinated colas	___ ___ ___
Flu	_____	Used other drugs	___ ___ ___
Pneumovac	_____	Drank Alcohol	___ ___ ___
		Exercise Regularly	___ ___ ___

FAMILY HISTORY	IF LIVING		IF DECEASED	Has any blood relative ever had: (If yes, please circle) and note which relative.
	AGE	HEALTH	Age at Death	
Father				Cancer or leukemia
Mother				Diabetes
Brothers/Sisters				Heart Attack
1				High blood pressure
2				Mental Illness
3				Tuberculosis
4				Alcoholism
5				Bleeding disorders
6				Kidney Disease
CHILDREN				Migraine Headaches
1				Stroke
2				Allergies or Asthma
3				Overweight
4				Seizures
5				Other:

SOCIAL HISTORY: Married Widowed Single Divorced . If M, W, or D, how long? _____

Educational level: _____ Grade School ___yrs, High school ___yrs., College ___yrs. Other ___

Occupation _____ Religion _____ Hobbies _____

Travel _____ Military Service _____ Stress _____ Insurance _____

SURGERIES/HOSPITALIZATIONS Please list all surgeries and hospitalizations (Except deliveries)

Date Surgery or reason for hospitalization Where Doctor

- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

MEDICAL HISTORY Main Problems (1) _____ (2) _____
 (3) _____ (4) _____ (5) _____

Check line and indicate age when you had any of the following symptoms or diseases:

- ____ Decreased hearing ____ Leg Pain when walking ____ Chronic Fatigue
- ____ Ringing in ear ____ Varicose Veins/Phlebitis ____ Weight loss-recent
- ____ Ear infections-recent ____ Loss of Appetite-recent ____ Anemia ____ Bruise easily
- ____ Dizzy Spells ____ Difficulty Swallowing ____ Cancer
- ____ Failing Vision ____ Indigestion/heartburn ____ Diabetes
- ____ Double or blurred vision ____ Persistent nausea or vomiting ____ Thyroid disease
- ____ Eye pain ____ Peptic Ulcers ____ Convulsions or seizures
- ____ Eye infections-frequent ____ Abdominal pain-chronic ____ Stroke
- ____ Nose Bleeds-recurrent ____ Changes in bowel habits ____ Muscle weakness
- ____ Sinus trouble ____ Diarrhea ____ Constipation ____ Tremor or hands shaking
- ____ Sore throats-frequent ____ Diverticulosis ____ Numbness/tingling sensation
- ____ Hay fever or Allergies ____ Bloody or tarry stools ____ Headaches-frequent
- ____ Hoarseness-prolonged ____ Hemorrhoids ____ Arthritis/rheumatism
- ____ Pneumonia/Pleurisy ____ Gallbladder trouble ____ Back pain-recurrent
- ____ Bronchitis or chronic cough ____ Jaundice or hepatitis ____ Fractured bones or joint injury
- ____ Asthma / wheezing ____ Hernia ____ Gout ____ Foot Pain
- ____ Shortness of breath ____ on exertion ____ Lying flat ____ Urine infections-frequent ____ Cold numb feet
- ____ Chest pain ____ Painful urination ____ Rashes ____ Hives
- ____ High blood pressure ____ Blood in urine ____ Psoriasis ____ Eczema
- ____ Heart Murmur ____ Urination during the night >twice ____ Sleeping difficulty
- ____ Palpitations ____ Lack of control of urine ____ Nervousness ____ Depression
- ____ Irregular pulse ____ Decrease in force of urination ____ Memory Loss
- ____ Swollen ankles ____ Kidney stones ____ Excessive moodiness
- ____ Fainting spells ____ Sexually transmitted disease ____ Phobias
- ____ Urethral discharge ____ Mental Illness
- ____ Chicken Pox ____ Measles ____ Mumps ____ Polio ____ German Measles
- ____ Rheumatic fever ____ Scarlet fever ____ Tuberculosis
- ____ Osteoporosis ____ High cholesterol ____ High triglycerides

OTHER SYMPTOMS, DISEASES, OR INJURIES:

Do you feel safe? Y N Have you ever been abused? Y N

FEMALES--GYNECOLOGICAL HISTORY: Age of onset of menstrual cycle _____

Regular ____ Irregular ____ Flow: ____ Heavy ____ Moderate ____ Light Days of Flow ____ Length of cycle ____

____ Pain/cramps with menstrual flow ____ Pain/bleeding after intercourse

Age menstrual cycle stopped ____ Hot flashes Y N Do you take hormone replacement Y N If so what: _____

Number of pregnancies ____ # of live births ____ # of miscarriages ____ # of abortions ____

Birth control method _____ If on birth control pill, please give name of pill _____

Date of last pap smear _____ Result _____

Date of last mammogram _____ Result _____