FAMILY CONVENIENCE CLINIC

ALLKIDS MEDICAL

PATIENT HISTORY

Do you have any allergies to medications/foods? YES NO
If yes, please list: _____
Are you currently taking any medications? YES NO
If yes, please list: _____
Are your immunizations up to date? YES NO
Are there any problems you are currently being treated for? YES NO
If yes, please list: _____

Do any of your immediate family members have or had the following?
Arthritis: YES NO If yes, who: _____
Cancer: YES NO If yes, who: _____
Stroke: YES NO If yes, who: _____
Kidney Disease: YES NO If yes, who: _____
Diabetes: YES NO If yes, who: _____
Tuberculosis: YES NO If yes, who: _____
High Blood Pressure: YES NO If yes, who: _____
Heart Disease: YES NO If yes, who: _____

Do you use tobacco products? YES NO
If yes, how many packs per day ____ dip cans per day _____

Do you use an E-cigarette or vape? YES NO

SURGICAL HISTORY – Please list any surgeries: _____
_____
_____
_____
_____

WOMEN ONLY:

Number of pregnancies _____Number of Live Births _____Number of Abortions _____Number of Miscarriages _____

Current form of Birth Control: _____

PAST MEDICAL HISTORY

Please identity and explain, if needed, any current or past illness of the patient:

Anxiety Disorder:	YES NO	Heart Disease:	YES NO
Arthritis:	YES NO	High Cholesterol:	YES NO
Asthma:	YES NO	Hypertension:	YES NO
COPD:	YES NO	Hyperthyroidism:	YES NO
Cancer:	YES NO	Hypothyroidism:	YES NO
Coronary Artery Disease:	YES NO	Kidney Disease:	YES NO
Depression:	YES NO	Osteoporosis:	YES NO
Diabetes:	YES NO	Pulmonary:	YES NO
Diverticulitis:	YES NO	Reflux/GERD:	YES NO
Fibromyalgia:	YES NO	Stroke:	YES NO
Gout:	YES NO		
Eczema:	YES NO		

Who is your Primary Care Provider?

_____

Do you see any Specialist? If so, please list:

_____

_____

_____

_____

I certify the above information is true and correct to the best of my knowledge

Signature of Parent/Legal Guardian of Minor:_____Date:_____
(Relationship to Patient)

DO NOT SIGN BELOW THIS LINE UNLESS INSTRUCTED BY FRONT OFFICE STAFF

Annual Update 1: I certify the above information (circle one): has not changed has been updated

Signature of Parent/Legal Guardian of Minor:_____Date:_____
(Relationship to Patient)

Annual Update 2: I certify the above information: has not changed has been updated

Signature of Parent/Legal Guardian of Minor:_____Date:_____
(Relationship to Patient)