GRACE CLINIC®

Patient Care Form

Full Legal Name (Please Print): _____

Today's Date: _____ Birthday: _____

Email: _____

Primary Care Physician: _____ Other Physicians: _____

The main reason I came to the clinic today is: _____

How did you hear about The Walk-In Clinic at Grace? ☐ Advertisement (TV, Radio, Print) ☐ Friends ☐ Family

☐ My doctor outside of Grace Clinic: _____

Medical History: Please check any current significant medical problems.

☐ Diabetes (☐ Type 1/ ☐ Type 2) ☐ Coronary artery disease (heart attack) ☐ High blood pressure ☐ Asthma
☐ COPD (emphysema) ☐ High cholesterol ☐ Thyroid problems
☐ Arthritis - Type, if known: _____ ☐ Cancer - Type, if known: _____
☐ Other: _____

Medications: The medications I take are (including over-the-counter, vitamins, herbs):

Name:	Dose:	Frequency:	Name:	Dose:	Frequency:

My pharmacy: _____ Address/phone number if known: _____

Allergies: The allergies or drug reactions I have are:

Drug or Substance:	Reaction	Comments:

Surgeries: The surgeries I have had include:

Procedure	Date of Surgery	Surgeon	Comments
	____/____/____		
	____/____/____		
	____/____/____		

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Review of Symptoms:

Please check ALL current problems.

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other

EYES
- Please circle right, left or both
- ☐ Vision changes (R/L)
- ☐ Eye injury (R/L)
- ☐ Eye irritation (R/L)
- ☐ Other

EARS
- Please circle right, left or both
- ☐ Hearing loss (R/L)
- ☐ Earache (R/L)
- ☐ Other

NOSE
- ☐ Nasal congestion
- ☐ Sinus problems
- ☐ Nosebleed
- ☐ Other

MOUTH AND THROAT
- ☐ Sores in mouth
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Other

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Swelling of hands or feet
- ☐ Other

RESPIRATORY
- ☐ Cough
- ☐ Difficulty sleeping
- ☐ Wheezing
- ☐ Other

GASTROINTESTINAL
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Bloody stools
- ☐ Other

GENITOURINARY
- ☐ Pain with urination
- ☐ Frequent urination
- ☐ Difficulty starting or maintaining urination
- ☐ Sexual difficulties
- ☐ Other

MUSCULOSKELETAL
- ☐ Muscle cramps or aches
- ☐ Joint pain or swelling
- ☐ Back pain
- ☐ Other

SKIN
- ☐ Rash
- ☐ Itching
- ☐ Suspicious lesions
- ☐ Other

BREASTS
- ☐ Lumps or masses
- ☐ Nipple discharge
- ☐ Tenderness
- ☐ Other

NEUROLOGICAL
- ☐ Headaches
- ☐ Seizures
- ☐ Weakness or numbness
- ☐ Other

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ Other

ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst or urination
- ☐ Other

HEMATOLOGICAL
- ☐ Abnormal bruising
- ☐ Abnormal bleeding
- ☐ Other

ALLERGY
- ☐ Seasonal allergies
- ☐ Other

I have answered the above questions to the best of my ability.

Signed: _____ Date: ____/____/____

For office use only:

☐ Send a copy of today's office visit to the patient's primary care physician.

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Family History:

Please check all health problems for family members.

Family Member	Age (if living) or Age at Death	Diabetes	Stroke	Heart Disease	Cancer (Type, if known)	Other (please explain)
Father:		☐	☐	☐	☐	☐
Mother:		☐	☐	☐	☐	☐
Spouse:		☐	☐	☐	☐	☐
Brothers/Sisters:		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
Children:		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐

Social History:

Current marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed • Number of children: _____

• Occupation: _____ • Education (highest level attained): _____

Habits:

☐Y ☐N Alcohol
If yes, drinks/day _____

☐Y ☐N Cigars
If yes, cigars/day _____

☐Y ☐N Caffeine
If yes, servings/day _____

☐Y ☐N Cigarettes
If yes, cigarettes/day _____

☐Y ☐N Smokeless tobacco
If yes, amount/day _____

☐Y ☐N Street drugs - If yes, please describe: _____

Immunizations:

	Date received	Comments
Tetanus:	___/___/___	
Hepatitis B:	___/___/___	
Flu Vaccine:	___/___/___	
Pneumonia:	___/___/___	

To be filled out by WOMEN only:

• Total pregnancies? _____ • Total births? _____ • Miscarriages? _____ • Abortions? _____

• Present type of birth control: _____

• How long have you been using this method? _____ • Date last mentrual period began (if applicable) ___/___/___