IMC IMMEDIATE MEDICAL CARE, P.A.
From Urgent Care to Family Care For Adults and Children

General Medical History

Patient_____Age:___ Sex:☐M ☐F DOB:_____

Please answer the following questions. If you do not know the answer, please circle the question.
Please list all hospitalizations, surgeries and related dates:

_____

_____

Drug allergies:_____
Medications you are currently taking:_____

Please check if you, your parents, siblings or children have ever been diagnosed with any of the following:
☐Heart disease ☐High blood pressure ☐Cancer ☐Diabetes ☐Stroke
If yes, please list relationship:_____

Please list any other family illness:_____

Do you currently smoke? ☐Yes ☐ No If no, are you a former smoker? ☐Yes ☐No
If yes, how many packs per day?_____ If yes, when did you quit?_____
Drink alcohol ☐Daily ☐Weekly ☐Occasionally ☐Never

Have you ever been diagnosed with any of the following?

	Yes	No		Yes	No
1.	☐	☐	Eye trouble glaucoma, cataract or surgery		
2.	☐	☐	Wear glasses or contacts		
3.	☐	☐	Difficulty hearing speech		
4.	☐	☐	Ringing in ears		
5.	☐	☐	Frequent or sever headaches		
6.	☐	☐	Dizziness, vertigo or balance problems		
7.	☐	☐	Severe shortness of breath		
8.	☐	☐	Asthma		
9.	☐	☐	Hay fever requiring medicine or shots		
10.	☐	☐	Chronic cough or cold		
11.	☐	☐	Bronchitis or emphysema		
12.	☐	☐	Tuberculosis		
13.	☐	☐	Rib fracture		
14.	☐	☐	Heart murmur		
15.	☐	☐	High blood pressure		
16.	☐	☐	Heart attack		
17.	☐	☐	Severe palpitations or irregular heartbeat		
18.	☐	☐	Chest pain		
19.	☐	☐	Hepatitis, liver trouble, jaundice		
20.	☐	☐	Persistent indigestion or reflex		
21.	☐	☐	Colitis or recurrent bowel trouble		
22.	☐	☐	kidney trouble or kidney stones		
23.	☐	☐	Recurrent urinary tract infections		
24.	☐	☐	Cancer		
25.	☐	☐	Breast disease		
26.	☐	☐	Frequent chills, fever or night sweats		
27.	☐	☐	Muscle or joint problems		
28.	☐	☐	Arthritis		
29.	☐	☐	Knee pain		
30.	☐	☐	Broken or fractured bones		
31.	☐	☐	Easy bleeding or bruising		
32.	☐	☐	Swelling of ankles or varicose veins		
33.	☐	☐	Brain injury or stroke		
34.	☐	☐	Seizure, convulsions, epilepsy, paralysis		
35.	☐	☐	Skin disease including change in moles		
36.	☐	☐	Depression or mental illness		
37.	☐	☐	Prior drug or alcohol treatment		
38.	☐	☐	Wear special medical devices or implants		
39.	☐	☐	Recent weight gain or loss		
40.	☐	☐	Concussions		
41.	☐	☐	Hernia		
42.	☐	☐	Anemia		

Other medical illness:_____
_____
If yes to above, please identify by # and describe
#☐ _____
_____
#☐ _____
_____
#☐ _____
_____

Date of last Tetanus Shot:_____ The Center for Disease Control and Prevention recommend vaccine is needed every 10 years all through life.

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