West @ 4722 W. Kellogg Dr.
316-440-2565 fax 316-440-2750
Northwest @ 3560 N. Maize Rd.
316-669-3851 fax 316-358-9832

East @ 5838 E. Central Ave.
316-440-4595 fax 316-440-4596
South @ 7030 S. Broadway St.
316-558-5950 fax 316-558-5951

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Patient History Form - Membership

IMMEDIATE MEDICAL CARE, P.A.

Name:______________________________ Birth Date: ______________________________

Marital Status: ________________________ Occupation: ___________________________

Allergies to Medications, Latex or Dyes:

None Yes If yes, please list. ______________________________

____

Medications (Prescriptions, OTC, Vitamins, Supplements) Please list: (Name, Dose, Frequency)

____

____

____

____

Surgeries/Hospitalizations/Serious Injuries: List type & year

____

____

____

Immunizations	Y	N		Y	N
Hepatitis B Series			Recent Pneumonia Vaccine		
Gardasil Series			Recent Flu Vaccine		
Chicken Pox Immunization or disease			Positive TB Screening		
COVID (Type)			Measles Mumps Rubella		

Health Maintenance	Y	N	Year__		Y	N	Year
Colonoscopy				Bone Density			
Mammogram				Eye Exam			
Pap Smear				Physical Exam			
EKG				Chest X-Ray			

Social History	Y	N	
Smoking			Packs/Day /Years Quit year |
Alcohol			Drinks/day Drinks/week
Caffeine			Drinks/day
Recreational Drugs			Type & Frequency
Special Diet			If yes please describe:
Regular Exercise			If yes please describe:
Sexually Active			Men Women Both

GYN History	OB History
Age of first Menses: Menopause Age began:	Total number of Pregnancies:
Regular Periods? Y N Painful Periods? Y N	Full Term Births: Pre-Term Births:
PMS: Y N Describe if yes:	Miscarriages: Abortions:
Abnormal Pap: Y N If yes, Date:	Tubal: Hysterectomy: Year:
Pain with intercourse: Y N	Content with Sex Life: Y N
If yes, Describe:	

Medical History (Check if Positive)

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	ENT		**SKIN**		**ENDOCRINE**
	Eye Problems		Psoriasis		Diabetes
	Sinus Problems		Skin Disorders		Thyroid Disease
	Hearing Loss		Melanoma		Pancreatitis
	PULMONARY		**MUSCULOSKELETAL**		**NEUROLOGICAL**
	Asthma		Arthritis/Osteo		Concussions
	Emphysema/COPD		Arthritis/Rheumatoid		Headaches
	Shortness of Breath		Gout		Migraines
	Sleep Apnea		Neck/Spinal Problems		Epilepsy/Seizures
	GENITOURINARY		**HEMATOLOGICAL**		**PSYCHOLOGICAL**
	Urinary Infections		Anemia		ADD/ADHD
	Kidney Disease/Stones		Bleeding Disorders		Anxiety
	Erectile Dysfunction		Blood Clots		Depression
	STD		Cancer		Memory Loss
	Urinary Incontinence		Sickle Cell Disease		OCD
	Bladder Infections				Suicidal Thoughts/Attempts
	CARDIOVASCULAR		**GASTROINTESTINAL**		**OTHER: NOT LISTED**
	Abnormal EKG		Acid Reflux		
	Chest Pain		Constipation		
	Heart Attack		Diarrhea		
	Heart Disease		Irritable Bowel		
	High Blood Pressure		Gall Bladder Disease		
	High Cholesterol		Hernia		
	Stroke		Liver Disease		
	Peripheral Vascular Disease				

Family History (Please check all known that apply)

Illness	Father	Mother	Sibling	Child	Maternal G-Mother	Maternal G-Father	Paternal G-Mother	Paternal G-Father	Other
Asthma									
Bleeding Disorder									
Breast Cancer									
Depression/Anxiety									
Diabetes									
Drug/Alcohol Addiction									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Kidney Disease									
Leukemia									
Liver Disease									
Lung Cancer									
Osteoporosis									
Ovarian Cancer									
Pancreatic Cancer									
Rheumatoid Arthritis									
Stroke									
Thyroid Disease									
Other:									