



HEALTH QUESTIONNAIRE

Corona Urgent Care
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Chino Urgent Care
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 12555 Central Ave., Suite C
 Chino, CA 91710

NAME: _____ AGE: _____ DATE: _____

ADDRESS: _____ PHONE: (____) _____

REASON FOR THIS VISIT: ROUTINE _____ WORK INJURY _____

ILLNESS _____ OTHER _____

HISTORY OF PAST ILLNESS:

Have you had childhood:

Measles	No	Yes	Rheumatic fever or heart disease	No	Yes
Mumps	No	Yes	Tuberculosis	No	Yes
Chickenpox	No	Yes	Venereal disease	No	Yes
Diabetes	No	Yes	Congenital Abnormalities	No	Yes
Strokes	No	Yes	Other serious diseases	No	Yes
Cancer	No	Yes		No	Yes

Adult

Have you had any serious illness?	No	Yes
Have you ever been hospitalized or been under medical care for very long?	No	Yes
If "Yes", for what reason?	_____	

Operations

Have you had any surgery? Please list below	No	Yes
_____	_____	_____

Injuries

Have you had any broken bones?	No	Yes
Have you had any head concussions or injuries?	No	Yes
Have you ever been knocked unconscious?	No	Yes

FAMILY HISTORY	IF LIVING		IF DECEASED		HAS ANY BLOOD RELATIVES EVER HAD		
	Age	Health	Age (at death)	Cause		No	Yes
Father					Cancer	No	Yes
Mother					Tuberculosis	No	Yes
Brother / Sister					Diabetes	No	Yes
					Heart Trouble	No	Yes
					High Blood Pressure	No	Yes
Husband / Wife					Stroke	No	Yes
Son / Daughter					Convulsions	No	Yes
					Suicide	No	Yes
					Insanity	No	Yes
					Bleeding Tendency	No	Yes
					Gout or other Arthritis	No	Yes

SOCIAL HISTORY:

Circle One: Single Married Separated Divorced Widowed
 Are you living with your spouse? No Yes
 Is your sex life satisfactory? No Yes
 Do you have more than one sexual partner? No Yes
 Do you have dependants at home? No Yes
 Alcoholic Beverages: Never: ___ Rarely: ___ Moderate: ___ Daily: ___ Ever? _____
 Tobacco/Cigarettes: Packs a Day: ___ Don't Smoke: ___ Ever Smoke? _____
 Use of Recreational Drugs: Never: ___ Rarely: ___ Moderate: ___ Daily: ___ Ever? _____
 Are you employed? Full Time: ___ Part Time: ___
 What is your job? _____

Are you exposed to fumes, dusts or solvents? _____

How much time have you lost from work because of your health during the past:

Six Months: _____
 One Year: _____
 Five Years: _____

SYSTEMIC REVIEW: Do you have any of the following:

General:

Recent weight change	No	Yes
Have you been in good health most of your life	No	Yes

Skin:

Skin Disease	No	Yes
Jaundice	No	Yes
Hives, eczema or rash	No	Yes
Frequent infection or boils	No	Yes
Abnormal pigmentation	No	Yes

Head-Eyes-Ears-Nose-Throat

Eye disease or injury	No	Yes
Do you wear glasses	No	Yes
Double vision	No	Yes
Headaches	No	Yes
Glaucoma	No	Yes
Itching eyes or nose	No	Yes

Head-Eyes-Ears-etc. (cont'd):

Sneezing/runny nose	No	Yes
Nosebleeds	No	Yes
Chronic sinus trouble	No	Yes
Ear disease	No	Yes
Impaired hearing	No	Yes
Dizziness or episodes of unconsciousness	No	Yes
Neck:		
Stiffness	No	Yes
Thyroid trouble	No	Yes
Enlarged glands	No	Yes
Respiratory:		
URI (Cold) now	No	Yes
Spitting up blood	No	Yes
Chronic or frequent cough	No	Yes

SYSTEMIC REVIEW: (continued)

Respiratory: (continued) :

Asthma	No	Yes
Difficulty breathing	No	Yes
Any trouble with lungs	No	Yes
Pleurisy or Pneumonia	No	Yes

Cardio vascular:

Chest pain or angina pectoris	No	Yes
Shortness of breath walking or lying down	No	Yes
Difficulty walking two blocks	No	Yes
Heart trouble or heart attacks	No	Yes
High blood pressure	No	Yes
Swelling of hands, feet or ankles	No	Yes
Awakening in the night smothering	No	Yes
Heart murmur	No	Yes

Gastrointestinal:

Peptic ulcer (stomach or duodenal)	No	Yes
Vomiting blood or food	No	Yes
Gallbladder disease	No	Yes
Liver trouble	No	Yes
Hepatitis	No	Yes
Painful bowel movements	No	Yes
Bleeding with bowel movements	No	Yes
Black stools	No	Yes
Hemorrhoids or piles	No	Yes
Recent change in bowel habits	No	Yes
Frequent diarrhea	No	Yes
Heartburn or indigestion	No	Yes
Does food stick in throat	No	Yes

Genitourinary:

Loss of urine	No	Yes
Frequent urination	No	Yes
Night time urinating	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Kidney trouble	No	Yes
Kidney stones	No	Yes
Bright's disease	No	Yes

Gynecological:

Age periods started	_____
How long do periods last	_____ Days

Gynecological (continued):

Number of pregnancies	_____
Nosebleeds	_____
Date of last cancer smear & results	_____

Frequency of periods	_____	Days
Any pain with periods	No	Yes
Date of first day of last period	_____	
Number of children & ages	_____	

Locomotor-Musculoskeletal :

Varicose veins	No	Yes
Muscle or joint weakness	No	Yes
Difficulty walking	No	Yes
Pain in calves or buttocks while walking (relieved by rest)	No	Yes

Neuro-Psychiatric

Have you had psychiatric care	No	Yes
Been advised to see a psychiatrist	No	Yes
Have or had fainting spells	No	Yes
Convulsions	No	Yes
Paralysis	No	Yes

Hematological

Are you slow to heal after cuts	No	Yes
Blood disease	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Have you had difficulty with bleeding excessively after tooth extraction or surgery	No	Yes

Allergic:

Any allergies including medication	No	Yes
Endocrine	No	Yes
Thyroid disease	No	Yes
Hormone therapy	No	Yes
Any change in hat or glove size	No	Yes
Any change in hair growth	No	Yes
Have you become colder than before or skin become dryer	No	Yes

HEIGHT _____

WEIGHT _____

ALLERGIES & SENSITIVITIES

1. Date of last tetanus: _____

2. Is there a history of skin reaction or other reaction/sickness following injection or oral administration of:

Circle One

Please list your present medications

Penicillin or other antibiotics	No	Yes	Don't Know
Morphine, Codeine, Demerol, other narcotics	No	Yes	Don't Know
Novocain or other anesthetics	No	Yes	Don't Know
Aspirin, empirin or other pain remedies	No	Yes	Don't Know
Sulfa drugs	No	Yes	Don't Know
Tetanus antitoxin or other serums	No	Yes	Don't Know
Adhesive tape	No	Yes	Don't Know
Iodine or merthiolate	No	Yes	Don't Know
Any foods, such as egg, milk or chocolate	No	Yes	Don't Know

3. Drugs taken within the past six months:

Aspirin	No	Yes	Don't Know
Cortisone	No	Yes	Don't Know
ACTH	No	Yes	Don't Know
Anticoagulants	No	Yes	Don't Know
Tranquilizers	No	Yes	Don't Know
Hypotensives	No	Yes	Don't Know

4. Has the patient received treatment for:

Asthma, rheumatism or rheumatic fever	No	Yes	Don't Know
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Source of information, if other than patient: _____

Signature of person acquiring this information: _____

Doctor _____

Date _____

Signature of patient _____