



Heartland Medical Care, P.C.
10010 Truman Road
Independence, MO 64052
(816) 252-7800

Thank you for choosing our office. In order to care for you properly, we need the following information.

PLEASE PRINT- All information will be confidential.

Patient Name _____ Date of Birth _____ Patient # _____ Date _____

Chief Complaint _____

History of Present Illness:

Location: _____ Quality _____
(where is the pain/problem?) (example: normal versus abnormal color, activity, etc.)

Severity _____ Duration _____
(how severe is the pain/problem on a scale of 1-5 with 5 being the most severe) (how long have you had this pain/problem or when did it start?)

Timing _____ Context _____
(Does the pain/problem occur at a specific time?) (Where were you at the onset of this pain/problem.)

Associated signs/symptoms _____
(What other associated problems have you been having?)

Modifying Factors _____
(What makes the pain/problem worse or better? Have you had previous episodes?)

Past Medical History: Have you ever had the following? (circle "yes" or "no", leave blank if uncertain)

| | | | | | | | | | | | |
|------------------|----|-----|--------------------|----|-----|--------------------------|-------|-------------------|-------------------|-------|-------|
| Measles | no | yes | Anemia | no | yes | Back Trouble | no | yes | Hepatitis | no | yes |
| Mumps | no | yes | Bladder Infections | no | yes | High Blood Pressure | no | yes | Ulcer | no | yes |
| Chickenpox | no | yes | Epilepsy | no | yes | Low Blood Pressure | no | yes | Kidney Disease | no | yes |
| Whooping Cough | no | yes | Migraine Headaches | no | yes | Hemorrhoids | no | yes | Thyroid Disease | no | yes |
| Scarlet Fever | no | yes | Tuberculosis | no | yes | Date of last chest X-Ray | _____ | Bleeding Tendency | no | yes | |
| Diphtheria | no | yes | Diabetes | no | yes | Asthma | no | yes | Any other disease | no | yes |
| Smallpox | no | yes | Cancer | no | yes | Hives or Eczema | no | yes | _____ | _____ | _____ |
| Pneumonia | no | yes | Polio | no | yes | Aids or HIV+ | no | yes | _____ | _____ | _____ |
| Rheumatic Fever | no | yes | Glaucoma | no | yes | Infectious Mono | no | yes | _____ | _____ | _____ |
| Heart Disease | no | yes | Hernia | no | yes | Bronchitis | no | yes | _____ | _____ | _____ |
| Arthritis | no | yes | Blood or Plasma | no | yes | Mitral Valve Prolapse | no | yes | _____ | _____ | _____ |
| Venereal Disease | no | yes | Transfusions | no | yes | Stroke | no | yes | _____ | _____ | _____ |

| Previous Hospitalizations/surgeries/serious illnesses | When? | Hospital, City, State |
|---|-------|-----------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Medications: (include non-prescription) _____

Patient Social History

| | |
|---|---|
| Marital Status- single _____ married _____ separated _____ divorced _____ widowed _____ | Use of Tobacco: never _____ previously, but quit _____ Currently-# of packs a day _____ |
| Use of Alcohol - never _____ rarely _____ moderately _____ daily _____ | Excessive exposure at home or work to: fumes _____ dust _____ solvents _____ |
| Use of Drugs - never _____ Type/Frequency _____ | airborne particles _____ noise _____ |

| Family Medical History: | Age | Diseases | if Deceased cause of death |
|-------------------------|-------|----------|----------------------------|
| Father | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ |
| Siblings | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| Spouse | _____ | _____ | _____ |
| Children | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Please Fill Out Other Side

Review of systems: Please indicate any personal history below.

| | | |
|--|--|--|
| <p>Allergic/Immunologic History of skin reaction or other adverse reaction to: Penicillin or other antibiotics no yes Morphine, Demerol or other narcotics no yes Novocain or other anesthetics no yes Aspirin or other pain remedies no yes Tetanus antitoxin or other serums no yes Iodine, Merthiolate, or other antiseptic no yes Other drugs/medications: _____ _____ Known food allergies: _____ _____ Environmental allergies: _____ _____</p> <p>Cardiovascular Heart Trouble no yes Chest Pain or Angina Pectoris no yes Palpitations no yes Shortness of breath w/walking or lying flat no yes Swelling of feet, ankles, or hands no yes</p> <p>Constitutional Systems Good general health lately no yes Recent weight change no yes Fever no yes Fatigue no yes Headaches no yes</p> <p>Ears/Nose/Mouth/Throat Hearing loss or ringing no yes Earaches or drainage no yes Chronic sinusitis or rhinitis no yes Nose Bleeds no yes Mouth Sores no yes Bleeding Gums no yes Bad breath or bad taste no yes Sore throat or voice change no yes Swollen Glands in Neck no yes</p> | <p>Endocrine Glandular or hormone problem no yes Excessive thirst or urination no yes Heat or cold intolerance no yes Skin becoming drier no yes Change in hat or glove size no yes</p> <p>Eyes Eye disease or injury no yes Wear glasses/lenses no yes Blurred or double vision no yes</p> <p>Gastrointestinal Loss of appetite no yes Change of bowel movements no yes Nausea or vomiting no yes Frequent diarrhea no yes Painful bowel movements or constipation no yes Rectal bleeding or blood in stool no yes Abdominal pain no yes</p> <p>Genitourinary Frequent urination no yes Burning/painful urination no yes Blood in urine no yes Change in force of stream when urinating no yes Incontinence or dribbling no yes Kidney stones no yes Sexual difficulty no yes Male-testicle pain no yes Female – pain with periods no yes Female- irregular periods no yes Female – vaginal discharge no yes Female - # of pregnancies _____ Female- # of miscarriages _____ Female – date of last pap smear _____</p> <p>Hematologic/Lymphatic Slow to heal after cuts no yes Bleeding or bruising tendency no yes Anemia no yes Phlebitis no yes Past transfusion no yes Enlarged glands no yes</p> | <p>Integument (skin,breast) Rash or itching no yes Change in skin color no yes Change in hair or nails no yes Varicose veins no yes Breast pain no yes Breast lump no yes Breast discharge no yes</p> <p>Musculoskeletal Joint pain no yes Joint stiffness or swelling no yes Weakness of muscles/joints no yes Muscle pain or cramps no yes Back pain no yes Cold extremities no yes Difficulty walking no yes</p> <p>Neurological Frequent/reoccurring headaches no yes Light headed or dizzy no yes Convulsions or seizures no yes Numbness or tingling sensations no yes Tremors no yes Paralysis no yes Head injury no yes</p> <p>Psychiatric Memory loss or confusion no yes Nervousness no yes Depression no yes Insomnia no yes</p> <p>Respiratory Chronic or frequent cough no yes Spitting up blood no yes Shortness of breath no yes Wheezing no yes</p> |
|--|--|--|

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize Heartland Medical Care, P.C. health care staff to perform the necessary services I may need.

 Signature of Patient or Guardian

 Date

Doctor's Review

 Signature of Doctor

 Date