Date: ______________________________
Name of Patient: ______________________________
Social Security: ______________________________

## Health Inquires for Primary Care Provider

**Please place an "X" in the appropriate box.**

1. **Known Medical Conditions**

Do you know if you have any of the following conditions?

| | | | |
|---|---|---|---|
| a. | Heart Condition (including heart murmur)? | ( ) **Yes** | ( ) **No** |
| b. | Lung Condition? | ( ) **Yes** | ( ) **No** |
| c. | High Blood Pressure? | ( ) **Yes** | ( ) **No** |
| d. | Diabetes Mellitus (Sugar Diabetes)? | ( ) **Yes** | ( ) **No** |
| e. | Any Kind of Cancer? | ( ) **Yes** | ( ) **No** |
| f. | History of Stroke? | ( ) **Yes** | ( ) **No** |
| g. | Arthritis? | ( ) **Yes** | ( ) **No** |
| h. | History of Injuries? | ( ) **Yes** | ( ) **No** |

i. If yes please describe ______________________________
______________________________
______________________________

| | | | |
|---|---|---|---|
| j. | Were you exposed to Agent Orange? | ( ) **Yes** | ( ) **No** |
| k. | Were you exposed to Ionizing Radiation? | ( ) **Yes** | ( ) **No** |
| l. | Were you exposed to Environmental Hazards? | ( ) **Yes** | ( ) **No** |
| m. | Do you have any loss of Vision? | ( ) **Yes** | ( ) **No** |
| n. | Do you have any loss of Hearing? | ( ) **Yes** | ( ) **No** |

o. Any other Conditions? ______________________________
______________________________
______________________________

**2. History of Allergies**

Are you allergic to:

| | | | |
|---|---|---|---|
| a. | Any Medications? | ( ) **Yes** | ( ) **No** |
| b. | Any Food? | ( ) **Yes** | ( ) **No** |
| c. | Anything Else? | ( ) **Yes** | ( ) **No** |

d. What are the Allergies? ______________________________
______________________________
______________________________

3. **Past Surgical and Medical History**

| | | | |
|---|---|---|---|
| a. | Have you undergone any surgery in the past? | ( ) **Yes** | ( ) **No** |
| b. | Have you Received radiation and/or chemotherapy? | ( ) **Yes** | ( ) **No** |

If yes what Kind of Cancer? ______________________________

| **Imprint From Patient Data Card** | **MEDICAL RECORD**<br><br>**SUPPLEMENT TO PROGRESS NOTE FOR SPECIALIZED DISCIPLINES-VERTICAL** |
|---|---|

**Health Inquires for Primary Care Provider (Continued)**

**4. Medications**

| | | | |
|---|---|---|---|
| a. | Are you currently taking any medications? | ( ) Yes | ( ) No |
| b. | If yes, do you know what they are? | ( ) Yes | ( ) No |
| c. | Do you know when to take them? | ( ) Yes | ( ) No |
| d. | Do you know how many medications you take? | ( ) Yes | ( ) No |

e. If yes, please list them? ______________________________________________
______________________________________________
______________________________________________

**5. Family History**

Do you know if any of your relatives have or have the following conditions?

| | | | |
|---|---|---|---|
| a. | Cancer? | ( ) Yes | ( ) No |
| b. | Heart Disease? | ( ) Yes | ( ) No |
| c. | High Blood Pressure? | ( ) Yes | ( ) No |
| d. | Diabetes Mellitus (Sugar Diabetes) | ( ) Yes | ( ) No |
| e. | Blood Conditions (such as Sickle Cell or Anemia, etc.) | ( ) Yes | ( ) No |
| f. | "Blindness" | ( ) Yes | ( ) No |

**6. Cancer Screening (Males Only)**

Do you get annual exams for detection of the following

| | | | |
|---|---|---|---|
| a. | Prostate Cancer? | ( ) Yes | ( ) No |
| b. | Colon Cancer? | ( ) Yes | ( ) No |

**Cancer Screening (Females Only)**

Do you get annual exams for detection of the following?

| | | | |
|---|---|---|---|
| a. | Cancer of the Cervix? | ( ) Yes | ( ) No |
| b. | Breast Cancer? | ( ) Yes | ( ) No |
| c. | Colon Cancer? | ( ) Yes | ( ) No |
| d. | Are receiving care from a private Gynecologist? | ( ) Yes | ( ) No |
| | If yes: | | |
| 1. | Have you had self breast exam teaching? | ( ) Yes | ( ) No |
| 2. | Have you had self breast exam in the last year? | ( ) Yes | ( ) No |
| 3. | Have you had a Pap Smear in the last year? | ( ) Yes | ( ) No |
| 4. | Were you provided a follow-up regarding an abnormal mammogram and/or Pap Smear within 30 days? | ( ) Yes | ( ) No |

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|---|---|

## Health Inquires for Primary Care Provider (Continued)

**4. Medications**

a. Are you currently taking any medications? ( ) Yes ( ) No
b. If yes, do you know what they are? ( ) Yes ( ) No
c. Do you know when to take them? ( ) Yes ( ) No
d. Do you know how many medications you take? ( ) Yes ( ) No
e. If yes, please list them? ______________________________
______________________________
______________________________

**5. Family History**

Do you know if any of your relatives have or have the following conditions?

a. Cancer? ( ) Yes ( ) No
b. Heart Disease? ( ) Yes ( ) No
c. High Blood Pressure? ( ) Yes ( ) No
d. Diabetes Mellitus (Sugar Diabetes) ( ) Yes ( ) No
e. Blood Conditions (such as Sickle Cell or Anemia, etc.) ( ) Yes ( ) No
f. "Blindness" ( ) Yes ( ) No

**6. Cancer Screening (Males Only)**

Do you get annual exams for detection of the following

a. Prostate Cancer? ( ) Yes ( ) No
b. Colon Cancer? ( ) Yes ( ) No

**Cancer Screening (Females Only)**

Do you get annual exams for detection of the following?

a. Cancer of the Cervix? ( ) Yes ( ) No
b. Breast Cancer? ( ) Yes ( ) No
c. Colon Cancer? ( ) Yes ( ) No
d. Are receiving care from a private Gynecologist? ( ) Yes ( ) No
If yes:
1. Have you had self breast exam teaching? ( ) Yes ( ) No
2. Have you had self breast exam in the last year? ( ) Yes ( ) No
3. Have you had a Pap Smear in the last year? ( ) Yes ( ) No
4. Were you provided a follow-up regarding an abnormal mammogram and/or Pap Smear within 30 days? ( ) Yes ( ) No
5. Has your Gynecologist provided you with information about other treatment such as?
a) Birth Control? ( ) Yes ( ) No
b) Vulvovaginitis when needed? ( ) Yes ( ) No
c) Management of Menopause? ( ) Yes ( ) No
d) Other specific counseling
If Yes, such as: ______________________________

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|---|---|

**Health Inquires for Primary Care Provider (Continued)**

**7. Vaccinations**

| | | | |
|---|---|---|---|
| a. | Do you receive, yearly Flu Vaccine? | ( ) Yes | ( ) No |
| b. | Did you receive the Pneumonia Vaccine? | ( ) Yes | ( ) No |
| c. | Have you received a Tetanus Booster in the past ten years? | ( ) Yes | ( ) No |

**8. Other Tests**

| | | | |
|---|---|---|---|
| a. | Have you ever been tested for the following? | | |
| b. | T.B. (Tuberculosis)? | ( ) Yes | ( ) No |
| c. | Venereal Disease? | ( ) Yes | ( ) No |

**9. Health Habits**

| | | | |
|---|---|---|---|
| a. | Do you currently smoke cigarettes, cigars, or a pipe? | ( ) Yes | ( ) No |
| b. | Did you previously smoke any of the above? | ( ) Yes | ( ) No |
| c. | If yes, when did you quit the habit? | ( ) Yes | ( ) No |
| d. | Do you currently drink the following? | | |
| 1. | Beer | ( ) Yes | ( ) No |
| 2. | Wine | ( ) Yes | ( ) No |
| 3. | Other alcoholic beverages | ( ) Yes | ( ) No |
| e. | Did you ever drink any of the above? | ( ) Yes | ( ) No |
| | If yes, how much and how long? ______________________________ | | |
| f. | Do you do some kind of daily exercise? | ( ) Yes | ( ) No |
| g. | If yes, when did you quit the habit? | ( ) Yes | ( ) No |
| h. | Do you think you eat excessive amounts of salty foods? | ( ) Yes | ( ) No |
| i. | Have you taken illegal drugs? | ( ) Yes | ( ) No |
| | If yes, what kind? ______________________________ | | |

**10. Living Conditions**

| | | | |
|---|---|---|---|
| a. | Do you live alone? | ( ) Yes | ( ) No |
| b. | Do you live with a spouse? | ( ) Yes | ( ) No |
| c. | Do you live with others? | ( ) Yes | ( ) No |

**11. Do you have any reason to believe that you are at risk in contracting "Aids"?**

( ) Yes ( ) No

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|---|---|

**CHOOSE FROM COMBAT OR CONFLICT (CHECK ONE)**

1. **WORLD WAR I** ☐
2. **WORLD WAR II – EUROPE** ☐
3. **WORLD WAR II – PACIFIC** ☐
4. **KOREAN** ☐
5. **VIETNAM** ☐
6. **OEF** ☐
7. **OIF** ☐
8. **PERSIAN GULF WAR** ☐
9. **YUGOSLAVIA CONFLICT** ☐
10. **LEBANON CONFLICT** ☐
11. **GRENADA CONFLICT** ☐
12. **PANAMA CONFLICT** ☐
13. **SOMALIA CONFLICT** ☐
14. **OTHER** ☐

**COMBAT SERVICE DATES: ___/___/____ TO ___/___/____**
**CONFLICT DATES: ___/___/____ TO ___/___/____**

THE DIFFERENCE IN COMBAT AND CONFLICT ARE AS FOLLOWS:

CONFLICT LOCATION – YOU WERE SUPPORTING THE TROOPS DOING THE ACTUAL FIGHTING (i.e., FINANCE, ACCOUNTING, MEDICAL, COOKS)

COMBAT LOCATION – YOU WERE IN THE ACTUAL FIGHTING

MOTHERS FULL NAME ________________________________

FATHERS FULL NAME ________________________________

MULTIPLE BIRTH ___________YES / NO_____________