North Stonington Medical Walk In Center, PC

Visit Information:

Patient Name:__________________________________ **Date of Birth:**_________________
Reason for today's visit:_________________________________ **Today's Date:**_________
Pharmacy of choice:___________________________________**Town:**___________________

Review of Symptoms:

	Do you have: please circle		**If yes,explain:**
SKIN	Rashes, bumps, lumps, open sores or wounds	**YES NO**	___________________
HEAD, EYES,EARS	Failing eyesight, falls, seizures, vertigo**,**	**YES NO**	___________________
NOSE, THROAT LUNGS	Blackouts, hoarseness, nasal congestion Shortness of Breath, wheezing, blood in Sputum, chronic cough	**YES NO**	___________________
Heart	Chest pain, irregular heartbeat or pacemaker	**YES NO**	___________________
Bowels	Blood in stool, change in bowel habits,abdominal Pain, worrisome indigestion	**YES NO**	___________________
Bladder,Kidney	Trouble urinating, infections, blood in urine	**YES NO**	___________________
Emotional	Any mental health problems, depression or Suicidal thoughts	**YES NO**	___________________
Musculoskeletal	Arthritis, fractures, injuries, muscle weakness	**YES NO**	___________________

Patient History:
Past Medical Conditions(Please list conditions with approx dates**):**_____________________________
____
____

Current Medication with dosage(Please list non-prescriptions as well**):**________________________
____
____

Allergies Medication or Food :____

Personal Habits:
Do you smoke, chew tobacco or vape? **YES NO** If yes, how much_____ How long______
Are you a former smoker? **YES NO** If yes, when did you quit?_____________
Do you drink alcoholic beverages? **YES NO** If yes, how much________ How long_______

Past Surgeries: (Please list what type and approx date**):**___________________________________
____

Patient Name:______________________________DOB:___________Today's Date:________

Past Medical History:

Anemia	Yes No	Hepatitis	Yes No	Pneumatic Fever	Yes No
Arthritis	Yes No	Hernia	Yes No	Pneumonia	Yes No
Asthma	Yes No	High Cholesterol	Yes No	Polio	Yes No
Cardiac	Yes No	Hypertension	Yes No	Scarlet Fever	Yes No
Chicken Pox	Yes No	Infectious Mono	Yes No	Seizures/Epilepsy	Yes No
Depression	Yes No	Kidney Disease	Yes No	Stroke	Yes No
Diabetes 1or2	Yes No	Lyme Disease	Yes No	Thyroid Disease	Yes No
Diphtheria	Yes No	Measles	Yes No	Transfusion	Yes No
Glaucoma	Yes No	Mitral Valve Prol.	Yes No	Tuberculosis	Yes No
Heart Disease	Yes No	Mumps	Yes No	Whooping Cough	Yes No

Have you had Covid-19: Yes No If so, when_________

Family History:

	Father	Mother	Brother	Sister	Grandparent (please indicate Maternal/Paternal Grandmother/Grandfather)
Alcohol/drug Abuse:	_____	____	_____	____	____________________
Colon Cancer:	_____	____	_____	____	____________________
Depression:	_____	____	_____	____	____________________
Diabetes:	_____	____	_____	____	____________________
Genetic Disorder:	_____	____	_____	____	____________________
Heart Disease:	_____	____	_____	____	____________________
High Blood Pressure:	_____	____	_____	____	____________________
High Cholesterol:	_____	____	_____	____	____________________
Liver Disease:	_____	____	_____	____	____________________
Other Cancer:	_____	____	_____	____	____________________
Psychiatric illness	_____	____	_____	____	____________________