IMMEDIATE CARE MEDICAL CENTER
A PROFESSIONAL CORPORATION
CHICO • ORLAND

PREMIERE PRIMARY CARE

Health History Questionnaire

This Page Completed by Patient

Name:	Medical Record #
DOB:	Sex: ☐M ☐F
Employer:	Job Title:
Job Requirements:	

Please answer the following questions to the best of your knowledge explaining yes answers in space below	Yes	No
1. Have you been under the care of doctor or clinic within the last year?	☐	☑
2. Have you ever had serious operations, illnesses, or injuries?	☐	☑
3. Have you ever been hospitalized?	☐	☑
4. Do you have diabetes, thyroid disease or any other glandular problems?	☐	☑
5. Do you have any trouble hearing?	☐	☑
6. Do you have any eye problems that are not fully corrected by glasses?	☐	☑
7. Are you colorblind?	☐	☑
8. Do you wear contact lenses?	☐	☑
9. Have you ever had asthma, tuberculosis, chronic bronchitis or other respiratory/ lung problems?	☐	☑
10. Have you ever had heart trouble, high blood pressure, severe chest pain, or severe shortness of breath?	☐	☑
11. Have you ever had severe stomach pain, intestine or liver trouble?	☐	☑
12. Have you ever been treated for kidney or bladder trouble?	☐	☑
13. Have you ever had anemia, leukemia or other diseases of the blood?	☐	☑
14. Have you ever had any trouble with or x-rays of your back, neck or spine?	☐	☑
15. Have you ever had trouble with your legs, feet, arms, hands or any joints?	☐	☑
16. Have you ever had any of the following nervous system problems: fainting, severe/recurrent headaches, dizzy spells, blackouts, convulsions or paralysis?	☐	☑
17. Do you have a recurring skin condition or rash?	☐	☑
18. Are you now taking prescribed or non-prescribed medication for any reasons?	☐	☑
19. Have you had a drug or alcohol problem in the past five years?	☐	☑
20. Have you ever had a nervous or mental breakdown, depression, or anxiety attack?	☐	☑
21. Do you have any known allergies, known asbestos exposure, or exposure to other toxic substances?	☐	☑
22. Do you use tobacco products? If yes, indicate kind, amount and length of habit.	☐	☑
23. Do you have other health problems not previously mentioned? If yes, describe injury or illness below.	☐	☑
24. Do you have any disability or condition which would prevent you from working in the near future?	☐	☑
25. Have you ever received compensation or settlement for an injury or illness? If yes, describe below.	☐	☑
26. How many days have you been absent from work or school because of injury or illness in the last year?		
Explain any yes answers, including dates, to questions 1 through 26.		

I understand that the information provided in this questionnaire is used by the medical department to insure my safe and appropriate placement in workplace. If required, I agree to have a medical examination and am aware that false statements or the failure to disclose information may be sufficient to disqualify me from employment or, if employed, may result in my dismissal.

X _____ _____

Signature of patient **Date**

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Physical Examination

Name:				Date:
Height:	Weight:	Temp:	Pulse:	BP:

Check – Describe Abnormalities in Detail

	Normal	Abnormal	Describe:
1. General Appearance			
2. Skin (Incl Scalp)			
3. Eyes			
OPTHALMOSCOPIC			
4. Ears – External			
Drums & Canals			
Hearing (See Audio)			
5. Lymph Glands			
6. Nasal Passages			
7. Mouth: Teeth & Gums			
8. Tonsils & Pharynx			
9. Neck & Thyroid			
10. Breasts			
11. Lungs			
12. Heart			
13. Abdomen			
14. Hernia			
15. Spine and Back			
Straight Leg Raising			
Bending			
16. Joints			
17. Extremities			
18. Scars or Deformities			
19. Varicosities			
20. Neurological			
Patellar Reflexes			
Achilles Reflexes			
21. Other			

Glasses

Kind & Use
☐ None
☐ Always
☐ Bifocal
☐ Near Only
☐ Far Only
☐ Contacts

Vision

	Uncorrected		Corrected	
	Rt	Lt	Rt	Lt
Far Vision				
Near Vision				
Depth Perception				
Color Perception				

Urinalysis

Specific Gravity	PH
Albumin	Sugar

MD
NP
PA

X

Examiner's Signature