Comprehensive Care Center of Irvine
Patient Centered Healthcare

250 East Yale Loop, Suite 204
Irvine, CA 92604
(949)732-3530

Name: _____ Date: _____
Birthdate: _____ Previous Primary Physician: _____
Current Specialists: _____

Medications
Please list any medications with strength that you currently take regularly (including non-prescription)

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies
Please list any allergies to medications, foods or other

Medication	***Food***	***Other***

Medical History

Illnesses/Conditions
Do you have or have you ever had any of the following:

		Year
☐	Anemia	
☐	Anethesia complications	
☐	Anxiety	
☐	Arthritis	
☐	Asthma	
☐	Birth Defects	
☐	Cancer (type: _____)	
☐	Colitis	
☐	Concussion	
☐	Depression/Nervous Breakdown	
☐	Diabetes	
☐	Emphysema	
☐	Heart Attack/Heart Disease	
☐	High Blood Pressure	
☐	High Cholesterol	
☐	Kidney Disease	
☐	Liver Disease/Hepatitis	
☐	Migraine Headaches	
☐	Mitral Valve Prolapse/Murmur	
☐	Osteoporosis	
☐	Pneumonia	
☐	Rheumatic Fever	
☐	Seizure Disorder	
☐	Sexually Transmitted Disease	
☐	Stroke	
☐	Thyroid Disorder	
☐	Tuberculosis	
☐	Ulcer	

Surgical Procedures/Hospitalizations **Year**

_____ _____
_____ _____
_____ _____
_____ _____

Childhood Diseases **Year**

☐ Chickenpox _____
☐ Measles _____
☐ Mumps _____
☐ Polio _____
☐ Other: _____ _____

Gynecological History (women only)

Last menstrual period _____
How many pregnancies have you had? _____
How many children do you have? _____
Have you ever had an abnormal pap? _____
Have you had a hysterectomy? _____
Have your ovaries been removed? _____

Health Maintenance
When, if ever, did you last have any of the following:

_____ Cholesterol check
_____ Colonoscopy
_____ EKG/Cardiogram
_____ Mammogram
_____ Pap Smear
_____ Prostate exam
_____ Cardiac stress test
_____ Bone Density

List Year of Last Vaccinations:

_____ Tetanus (TD)
_____ TB Skin Test
_____ Pneumonia
_____ Hepatitis A
_____ Hepatitis B
_____ Shingles (Zostavax)

Comprehensive Care Center of Irvine
Patient Centered Healthcare

250 East Yale Loop, Suite 204
Irvine, CA 92604
(949)732-3530

Health Maintenance continued

Name: _____
Birthdate: _____

Family History

Has any blood relative ever had any of the following :

	Relative (mother, father, sister, children)		Living Age	Deceased Age (at death) & cause
Alcoholism		Father		
Asthma		Mother		
Bleeding problems		Brother		
Cancer				
Type:				
Diabetes		Sister		
Emphysema				
Glaucoma				
Heart Attack		Son		
Heart Disease				
High Blood Pressure				
Mental Illness / Suicide		Daughter		
Osteoporosis				
Seizures				
Stroke		Husband/Wife		
Thyroid				

Social History

Marital Status? ○ *Single* ○ *Married* ○ *Divorced* ○ *Widow* ○ *Partner*

Do you have children / dependents at home? ○ **Yes / No** ○ *How many?* _____

Are you employed? ○ **Yes / No** ○ *Occupation?* _____

Do you or have you ever smoked or chewed tobbacco? ○ **Yes / No** ○ *When?* _____ *Quit date?* _____

Packs/cans/bags per day _____/ yrs _____ *Type?* _____ *How often?* _____

Do you or have you ever used illegal drugs? ○ **Yes / No** ○ *Type?* _____ *How often?* _____

Do you drink alcohol? ○ **Yes / No** ○ *Type?* _____ *How often?* _____

Have you been exposed to toxic substances? ○ **Yes / No** ○

Do you drink caffeine daily? ○ **Yes / No** ○ *Type?* _____ *How often?* _____

Do you exercise regularly? ○ **Yes / No** ○ *Type?* _____ *How often?* _____

Do you wear seat belts? ○ **Yes / No** ○

Do you have a living will or advance directives? ○ **Yes / No** ○

What is your highest level of education?

Review of Symptoms

Please check any of the following that you are experiencing:

General ☐ Fatigue ☐ Fever ☐ Hopelessness ☐ Hot Flashes ☐ Insomnia ☐ Night Sweats ☐ Poor Concentration ☐ Recent Weight Loss / Gain ☐ Loss of Interest in Usual Activities

Skin ☐ Change in Pigmentation ☐ Eczema ☐ Hives ☐ Jaundice ☐ Rashes

ENT ☐ Change in Vision / Hearing ☐ Dizziness ☐ Enlarged Glands ☐ Glaucoma ☐ Headaches ☐ Hearing Loss ☐ Neck Stiffness ☐ Nose Bleeds ☐ Chronic Sinus or Ear Problems

Respiratory ☐ Asthma ☐ Difficulty Breathing ☐ Frequent Colds / Coughing ☐ Shortness of Breath ☐ Spitting up Blood

Cardiac ☐ Angina ☐ Chest Pain ☐ Difficulty Walking 2 Blocks ☐ Heart Murmur ☐ High Blood Pressure ☐ Palpitations ☐ Swelling of Hands / Feet

Gastrointestinal ☐ Abdominal Pain / Cramping ☐ Blood or Dark Stool ☐ Change in Bowel Habits ☐ Frequent Diarrhea ☐ Frequent Indigestion / Heartburn / Gas / Bloating ☐ Hepatitis ☐ Hemorrhoids ☐ Vomiting Blood

Genitourinary ☐ Difficulty Urinating ☐ Frequent Urination ☐ Loss of Bladder Control ☐ Unsatisfactory Sex Life

Musculoskeletal ☐ Joint Pain or Swelling ☐ Difficulty Walking ☐ Muscle Cramping or Weakness ☐ Varicose Veins

Neuropsychiatric ☐ Prior Treatment for Depression / Psychiatric Care ☐ Fainting Spells ☐ Paralysis ☐ Convulsions

Hematologic ☐ Easy Bruising ☐ Excessive Bleeding After Cuts ☐ Slow Healing After Cuts