STOCKTON
URGENT CARE
MEDICAL CLINIC, INC.
1148 W. HAMMER LANE 95209 • (209) 952-9696

COMPANY NAME ____________________

ADDRESS ____________________

SPECIAL REQUIREMENTS OR TESTS ____________________

CONSENT TO RELEASE OF MEDICAL INFORMATION

I hereby authorize Stockton Urgent Care Medical Clinic, Inc., their employees, agents and members of their staff to release the results of this exam form, along with any and all tests, lab, physical, objective and/or subjective observations used during or concerning said exam, to my employer and its staff and to anyone I may expressly or impliedly authorize release to.
I further release and hold harmless such examining organization of and from any claims and liabilities arising from the provision of such information. I have read the above and sign this authorization freely and voluntarily.

SIGNATURE ____________________ PRINT NAME ____________________

DATE ____________________

I. IDENTIFICATION

Name ____________________ Social Security No. ______-______-______

Address ____________________ City ______ St. ______ Zip ______

Company Name & Address ____________________ City ______ St. ______ Zip ______

Telephone: Home (___)______ Work (___)______ Date of Birth ______ Age ______ Sex ______

Race ______ Place of Birth ______ Marital Status ___ Single ___ Married ___ Separated ___ Divorced

Highest Level of Education ____________________

POSITION APPLIED FOR: ____________________

NOTE: Your age, sex and race are required to medically interpret results of certain laboratory tests. This data is used for no other purposes and is kept confidential.

II. FAMILY HISTORY

Check the appropriate boxes if any of the diseases listed below apply to your blood relatives. (Mother, Father, Sister, Brother, etc.) List their relation to you.

- ☐ Alcoholism or Drug Addiction
- ☐ Anemia or Blood Disease
- ☐ Arthritis
- ☐ Blindness or Deafness
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Genetic Disease or Birth Defect
- ☐ Glaucoma
- ☐ Heart Disease or Attack
- ☐ High Blood Pressure
- ☐ Problems with Anesthesia
- ☐ Psychiatric Disorder
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Other ____________________

If any of your blood relatives are deceased, please give age at death and cause of death. (Include children and stillbirths.)

RELATIONSHIP	AGE AT DEATH	CAUSE OF DEATH

III. SOCIAL HISTORY

TOBACCO USE

☐ Never Smoked

☐ Smoked cigarettes

______ Age started smoking

______ Number of cigarettes smoked per day.

(2, 5, ½ pack, 1 pack, 2 packs, 3 packs, more than 3 packs per day.)

☐ Used to smoke cigarettes.

______ Age first smoked.

______ Age quit smoking.

______ Number of cigarettes smoked per day when quit.

(2, 5, ½ pack, 1 pack, 2 packs, 3 packs, more than 3 packs per day.)

☐ Smoke a pipe.

______ Age first smoked pipe.

______ Number of pipe bowls smoked per day.

☐ Used to smoke a pipe.

______ Age first smoked a pipe.

______ Number of pipte bowls smoked per day when quit.

______ Age when quit smoking.

☐ Chew tobacco or dip snuff.

______ Age first used.

______ Amount used per day.

☐ Used to chew tobacco or dip snuff.

______ Age first used.

______ Amount used per day when quit.

______ Age when quit chewing tobacc[illegible] dipping snuff.

ALCOHOL CONSUMPTION

______ Never consumed alcohol.

______ Moderate alcohol consumption

______ Number of drinks per day.

______ Quit drinking.

______ Recovering alcoholic or drug addict.

______ Year you quit using alcohol and/or drugs.

EXERCISE

______ No exercise.

______ Exercise minimally.

(Golf, bowling, walking less than 2 miles per week.)

______ Exercise moderately.

Equivalent to 2 to 8 miles per week.)

______ Exercise strenuously.

Describe: ____________________

IV. PAST MEDICAL HISTORY

ALLERGIES

______ I have no known allergies to medications or chemicals.

______ I do have allergies to some medications and/or chemicals.

They are: ____________________

____

IMMUNIZATIONS

______ Received the usual childhood immunizations.

______ Received a Tetanus Booster — Date received: ____________

______ Received Pneumovax (pneumonia shot) — Date received: ____________

______ Received Flu Shot — Date received: ____________

MEDICATIONS

______ Take no medications on a regular basis. (Including over the counter products and birth control products.)

______ Take the following medications on a regular basis: ____________

TRANSFUSIONS

______ Have never received a blood or blood product transfusion.

______ Have received a transfusion. Date(s) of transfusion(s): ____________

HOSPITALIZATION

______ Have never been admitted to a hospital or had an operation.

______ Have had the following hospitalizations and/or operations: (Include dates and an explanation for each hospitalization and/or operation.)

____

____

____

____

V. WORK EXPOSURE HISTORY

☐ Have never been exposed to hazardous chemicals, hazardous wastes, dusts, or asbestos on the job or at home.

☐ Have had the following exposures: (Give dates, name of substance and approximate amount of exposure, if possible.)

☐ Acetates (Vinyl)	☐ Dyes, Pigments	☐ Lead, Mercury, Heavy Metals
☐ Arsenic	☐ Epoxy Resins	☐ Microwaves
☐ Asbestos	☐ Excessive Noise	☐ Nitrates and/or Nitrites
☐ Bacteria, Mold or Viruses	☐ Extreme Cold or Heat	☐ Radioactivity
☐ Cadmium, Beryllium	☐ Fiberglass	☐ Silica
☐ Chlorine, Freon	☐ Fluorides/Hydrocholoric Acid	☐ Solvents
☐ Coal Dust	☐ Formaldehyde	☐ Sulfide Gases
☐ Cotton Dust	☐ Herbicides	☐ Vinyl Chloride
☐ Cotton or Oils	☐ Insecticides	☐ Other ____________

Give details of any exposures checked above. If additional exposures have occurred, please list and give details below.

____

____

____

____

____

VI. REVIEW OF SYSTEMS

I consider myself to be in ☐ Good health ☐ Fair health ☐ Poor health.

Are you now under a physician's care?. ☐ Yes ☐ No

If yes, please give details: ______

Date of last physical examination ______

Indicate symptoms which are of current concern to you or which have required treatment by a health professional in the past year.

______

Are you now pregnant? ☐ Yes ☐ No

Check the appropriate box(es) below which apply to you.

HEAD
- ☐ Head Injury or Operations
- ☐ Frequent Headaches
- ☐ Migraine Headaches
- ☐ Other ______

THROAT
- ☐ Frequent Sore Throat
- ☐ Persistent Hoarseness
- ☐ Lumps or Tumors in Neck
- ☐ Difficulty Swallowing
- ☐ Other ______

NOSE
- ☐ Frequent Nosebleeds
- ☐ Sinus Infection
- ☐ Loss of Smell
- ☐ Difficulty Breathing
- ☐ Other ______

EARS
- ☐ Hearing Loss or Deafness
- ☐ Wear Hearing Aid
- ☐ Ear Infections
- ☐ Ringing in Ears
- ☐ Other ______

EYES
- ☐ Eyeglasses or Contacts Worn
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Blurriness or Double Vision
- ☐ Other ______

MOUTH
- ☐ Ulcers or Growth
- ☐ Chewing Problems
- ☐ Dentures or Plate
- ☐ Date of Last Dental Exam ______
- ☐ Other ______

SKELETAL SYSTEM
- ☐ Gout
- ☐ Bursitis
- ☐ Arthritis
- ☐ Tendinitis
- ☐ Muscle Weakness
- ☐ Other ______

BLOOD
- ☐ Anemia (Low Blood Count)
- ☐ Leukemia
- ☐ Low White Blood Cells
- ☐ Bleeding Tendency
- ☐ Easily Bruised
- ☐ Other ______

NEUROLOGIC
- ☐ Loss of Consciousness, Coma or Stroke
- ☐ Severe Dizziness/Vertigo
- ☐ Blackouts/Fainting Spells
- ☐ Numbness or Tingling
- ☐ Weakness of Body Part
- ☐ Memory Loss
- ☐ Balance Problems
- ☐ Seizure Disorder/Epilepsy/Fits
- ☐ Psychiatric Hospitalization
- ☐ Emotional Problems, describe: ______
- ☐ Other ______

ABDOMEN
- ☐ Stomach/Intestinal Ulcer
- ☐ "Nervous Stomach"
- ☐ Frequent Heartburn
- ☐ Liver Trouble/Jaundice
- ☐ Gallbladder Trouble
- ☐ Change in Bowel Habits
- ☐ Blood in Stool
- ☐ Black or Light Colored Stools
- ☐ Diverticulosis/Diverticulitis
- ☐ Hemorrhoids
- ☐ Other ______

CHEST & LUNGS
- ☐ Shortness of Breath with Exercise
- ☐ Shortness of Breath while Lying Flat
- ☐ Frequent Congestion
- ☐ Morning Cough
- ☐ Cough Up Blood
- ☐ Tightness or Constriction
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Other ______

FEMALES ONLY
- ☐ Date Most Recent Cycle Began ______
- ☐ Abnormal PAP Smear
- ☐ Date of Most Recent PAP Smear ______
- ☐ Ovarian Cyst or Tumor
- ☐ Fibroid Tumors
- ☐ Irregular Periods
- ☐ Excessive Bleeding with Periods
- ☐ Endometriosis
- ☐ Concern About Possible Infertility
- ☐ Breast Masses, Tenderness
- ☐ Date of Last Mammogram ______
- ☐ Other ______

SKIN
- ☐ Rashes
- ☐ Skin Cancer
- ☐ Excessively Dry or Oily Skin, circle which
- ☐ Irritation from Chemicals, describe: ______
- ☐ Other ______

HEART
- ☐ Chest Pain with Exercise (Angina)
- ☐ Chest Pain at Rest
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Heart Murmur
- ☐ Rapid or Irregular Heart Beat
- ☐ Palpitations (Fluttering)
- ☐ Swollen Feet or Ankles
- ☐ Other ______

MALES ONLY
- ☐ Penile Discharge or Burning
- ☐ Difficulty Passing Urine
- ☐ Prostate Infection or Other Disorder
- ☐ Testicular Swelling or Mass
- ☐ Concern About Possible Infertility
- ☐ Sexual Dysfunction
- ☐ Other ______

OTHER
- ☐ Thyroid Problem
- ☐ Cold or Heat Intolerance
- ☐ Weakness or Fatique
- ☐ Gained or Lost More than 10 Pounds in Last Year
- ☐ Varicose Veins or Blood Clots

URINARY
- ☐ Frequent Urination
- ☐ Bladder or Kidney Infections
- ☐ Kidney Disease or Failure
- ☐ Blood in Urine
- ☐ Other ______

REPRODUCTIVE
- ☐ Number of Pregnancies (You or Your Partner(s))
- ☐ Number of Children Born Normal (You or Your Partnner(s))
- ☐ Number of Children Born Abnormal (You or Your Partner(s))
- ☐ Number of Miscarriages or Stillbirths (You or Your Partner(s))

If any of the above boxes are checked, give details: ______