STAR Health UNIVERSITY of DELAWARE | Nurse Managed Primary Care Center

540 S. College Ave. Suite 130
Newark, DE 19713
Phone: 302-831-3195
Fax: 302-831-3193
Email: nm-hc@udel.edu

Name: **DOB:** **Date:**

Personal and Medical Information			
Check any of the medical conditions listed that **you** have been diagnosed with:	❑ High Blood Pressure ❑ Heart Disease ❑ High Cholesterol ❑ Kidney Disease	❑ Asthma ❑ Emphysema ❑ Cancer ❑ Anemia	❑ Diabetes ❑ Stroke ❑ Blood Clots
List any other medical diagnosis you have:			
Have you been hospitalized for any significant injury or illness: ❑ Yes ❑ No If **yes** list reason and dates:			

Check any of the medical conditions listed that either your **F**ather or **M**other have been diagnosed with:	**F** **M**	**F** **M**	**F** **M**
	❑ ❑ High Blood Pressure ❑ ❑ Heart Disease ❑ ❑ High Cholesterol ❑ ❑ Kidney Disease	❑ ❑ Asthma ❑ ❑ Emphysema ❑ ❑ Cancer ❑ ❑ Anemia	❑ ❑ Diabetes ❑ ❑ Stroke ❑ ❑ Blood Clots

If you are currently taking any prescription medicine, over-the-counter medicine, vitamins, herbs, nutritional supplements or birth control pills, please list the medication **name, dosage and frequency** taken below

1.	5.
2.	6.
3.	7.
4.	8.

Are you **ALLERGIC** to any medication, food or latex?	❑ Yes ❑ No	If yes what?		Type of reaction:	
Do you smoke?	❑ Yes ❑ No	If yes how much?		How many years?	
Did you ever smoke?	❑ Yes ❑ No	If yes, quit date?		# Yrs. smoked?	
Do you drink alcohol?	❑ Yes ❑ No	If yes how much?		How many years?	
Do you drink caffeinated drinks	❑ Yes ❑ No	If yes how much?		Type: ❑ Coffee ❑ Tea ❑ Soda	
Do you normally eat a balanced diet	❑ Yes ❑ No	Meals per day?		Snacks per day?	
Do you exercise on a regular basis?	❑ Yes ❑ No	Days per week #?		Type of:	
Do you live with others?	❑ Yes ❑ No	If yes who?	❑ Husband ❑ Wife	❑ Partner ❑ Children	❑ Single ❑ Roommate(s)

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Are you employed? ❑ Yes ❑ No If yes: ❑ Full time ❑ Part time ❑ Retired

Have you had any of the following immunizations? If yes, include last year you had the immunization.

	Year		Year		Year		Year
❑	Tetanus	❑	Flu Shot	❑	Pneumococcal	❑	Hepatitis B

Have you had any of the following tests? If yes, include last year you had the test.

	Year		Year		Year		Year
❑	EKG	❑	Stress Test	❑	Colonoscopy	❑	Mammogram

Check any symptoms and or conditions listed below that you have experienced in the **past 12 months**:

Vision: ❑ Change in far vision ❑ Change in near vision ❑ Blurred Vision

Hearing: ❑ Ear pain ❑ Loss of Hearing ❑ Ringing in Ears

Musculoskeletal ❑ Joint Pain ❑ Joint Stiffness ❑ Muscle weakness ❑ Unsteady Walking

Cardiovascular ❑ Chest pain ❑ Palpitations

Respiratory: ❑ Shortness of breath ❑ Wheezing ❑ Coughing ❑ Coughing up blood

Circulatory: ❑ Swelling of the Hands/Feet ❑ Leg Cramps with walking

Endocrine: ❑ Excessive thirst ❑ Frequent urination ❑ Unintentional Weight Change > 5 lb.

Gastrointestinal ❑ Diarrhea ❑ Constipation ❑ Blood in stools ❑ Heartburn

Neurological ❑ Headaches ❑ Numbness or tingling in extremities

Emotional: ❑ Depression ❑ Anxiety

I attest that this information is correct to the best of my knowledge.

X

Patients Signature: Date:

Reviewed by
Clinician's signature: Date: