PULSE
Urgent Care Center

Medical History Questionnaire

Please read carefully the following instructions for filling out this questionnaire. Complete and accurate forms will assist in your physical moving quicker and more efficient.

1. This questionnaire is a legal document.
2. The purpose of this questionnaire is to gather information concerning your health and physical condition, both current and past.
3. The information will be used only to determine whether you are in physically and mentally healthy enough to safely perform the duties of the position for why you are being considered.
4. You must answer all of the following questions as fully and completely as you can. To withhold or falsify information will result in immediate disqualification for the position in which you are applying.
5. **Each question must be answered individually**: please check mark each box. A continuous line or other indication that all answers are the same will not be accepted.
6. If you do not understand a question, or are unsure of how to answer please leave the question blank. The provider or other medical staff will provide clarification.

I agree that I have read and agree to the above instructions and will provide all the required information to the best of my ability.

Print Name: _____

Signature: _____ Date: _____

PULSE Urgent Care Center

Medical History Questionnaire

100 E Cypress Ave, Redding, CA 96001
Phone (530) 722-1111
Fax (530) 722-9999

Name _____ Date of Birth _____ Age _____ Social Security No. _____ Date _____

Address _____ City _____ State _____ Zip _____ Phone _____

Job Title _____ Department _____ Division _____

The purpose of this questionnaire is to gather information concerning your health and physical condition, both current and past. This information will be used only to determine whether you can safely perform the duties of the job for which you are being considered. Please answer all of the following questions as fully and completely as you can. If you do not understand a question, or are unsure of how to answer it, leave the question blank and medical professionals will assist you with clarification.

1. MEDICAL HISTORY
   a. **Medical conditions**

HEALTH CONDITION	NEVER HAD	PREVIOUSLY HAD	NOW HAVE	DON'T KNOW
HEAD, NOSE, MOUTH & THROAT				
Persistent or severe headaches	☐	☐	☐	☐
Frequent nose bleeds	☐	☐	☐	☐
Frequent nasal congestion	☐	☐	☐	☐
Persistent/severe sinus condition	☐	☐	☐	☐
Bleeding gums	☐	☐	☐	☐
Persistent/Severe dental condition	☐	☐	☐	☐
Hoarse when don't have cold	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐
Persistent sore throat	☐	☐	☐	☐
Loss of taste or smell	☐	☐	☐	☐
Other head, nose, mouth or throat condition Please list:				
EARS AND HEARING				
Hearing difficulties	☐	☐	☐	☐
Use hearing aids	☐	☐	☐	☐
Ringing in ears (*tinnitus*)	☐	☐	☐	☐
Perforated ear drum	☐	☐	☐	☐
Persistent or severe ear infection	☐	☐	☐	☐
Other ear or hearing conditions Please list:				
EYES AND VISION				
Glaucoma	☐	☐	☐	☐
Cataract	☐	☐	☐	☐
Eye infection	☐	☐	☐	☐
Defective vision	☐	☐	☐	☐
Color blindness	☐	☐	☐	☐
Injury to the eye	☐	☐	☐	☐
Eye surgery	☐	☐	☐	☐
Double vision	☐	☐	☐	☐
Glasses	☐	☐	☐	☐
Contact lenses	☐	☐	☐	☐
Other eye or vision conditions Please list:				
RESPIRATORY SYSTEM				
Persistent or severe colds/cough	☐	☐	☐	☐
Coughing blood	☐	☐	☐	☐
Asthma or wheezing	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Pneumonia	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
other respiratory system conditions Please list:				
CARDIOVASCULAR SYSTEM				
Heart attack	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Hardening of the arteries	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Heart murmur	☐	☐	☐	☐
Palpitations or irregular heart beat	☐	☐	☐	☐
Episodes of chest pain or tightness	☐	☐	☐	☐
Shortness of breath	☐	☐	☐	☐
Varicose veins	☐	☐	☐	☐
Swelling of ankles, feet or legs	☐	☐	☐	☐
Other cardiovascular system conditions Please list				

HEALTH CONDITION	NEVER HAD	PREVIOUSLY HAD	NOW HAVE	DON'T KNOW
GASTROINTESTINAL SYSTEM				
Persistent or severe nausea or indigestion	☐	☐	☐	☐
Persistent or severe stomach pain	☐	☐	☐	☐
Vomiting blood	☐	☐	☐	☐
Persistent or severe vomiting	☐	☐	☐	☐
Hernia (*rupture*)	☐	☐	☐	☐
Stomach or duodenal ulcer	☐	☐	☐	☐
Colitis	☐	☐	☐	☐
Hemorrhoids or piles	☐	☐	☐	☐
Change in bowel habits	☐	☐	☐	☐
Black stool	☐	☐	☐	☐
Blood in stool	☐	☐	☐	☐
Persistent or severe constipation	☐	☐	☐	☐
Persistent or severe diarrhea	☐	☐	☐	☐
Pancreatitis	☐	☐	☐	☐
Other conditions of stomach or intestines Please list:				
LIVER, SPLEEN & GALLBLADDER				
Cirrhosis	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐
Jaundice	☐	☐	☐	☐
Gallstones	☐	☐	☐	☐
Other conditions of liver, spleen or gallbladder Please list:				
KIDNEYS AND URINARY TRACT				
Kidney stones	☐	☐	☐	☐
Kidney infection	☐	☐	☐	☐
Blood in urine	☐	☐	☐	☐
Pain or burning when urinating	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Albumen or protein in urine	☐	☐	☐	☐
Prostate condition	☐	☐	☐	☐
Burning/discharge from penis (male only)	☐	☐	☐	☐
Other conditions of kidneys or urinary tract Please list:				
REPRODUCTIVE SYSTEM (*females only*)				
Breast lumps	☐	☐	☐	☐
Breast discharge	☐	☐	☐	☐
Reached menopause	☐	☐	☐	☐
Irregular periods	☐	☐	☐	☐
Bleeding between periods	☐	☐	☐	☐
Excessive bleeding during menstruation	☐	☐	☐	☐
Significant change in periods	☐	☐	☐	☐
Hysterectomy	☐	☐	☐	☐
Pregnancy	☐	☐	☐	☐
Difficulty becoming pregnant	☐	☐	☐	☐
REPRODUCTIVE SYSTEM (*male and female*)				
Sterilization (*vasectomy, tubal ligation, etc.*)	☐	☐	☐	☐
Diagnosed infertility problems	☐	☐	☐	☐
Change in sexual ability	☐	☐	☐	☐
Other reproductive system conditions Please list:				

Name _____

1. MEDICAL HISTORY (continued)

a. Medical History (continued)

HEALTH CONDITION	NEVER HAD	PREVIOUSLY HAD	NOW HAVE	DON'T KNOW
NEUROLOGICAL SYSTEM				
Epilepsy, convulsions, seizures	☐	☐	☐	☐
Periods of blackouts/loss of consciousness	☐	☐	☐	☐
Fainting spells	☐	☐	☐	☐
Dizzy spells (vertigo)	☐	☐	☐	☐
Memory difficulty	☐	☐	☐	☐
Tremor of the hands or head	☐	☐	☐	☐
Paralysis of any type	☐	☐	☐	☐
Persistent of severe numbness, tingling, weakness. If so list body part affected	☐	☐	☐	☐
Other neurological conditions Please list:				
PSYCHOLOGICAL/MOOD				
Mental condition requiring hospitalization	☐	☐	☐	☐
Suicidal thoughts or attempts	☐	☐	☐	☐
Desired/sought psychological help	☐	☐	☐	☐
Drug, narcotic or alcohol dependency	☐	☐	☐	☐
Persistent or severe depression/worry	☐	☐	☐	☐
Persistent or severe difficulty sleeping	☐	☐	☐	☐
Other psychological conditions Please list:				
MUSCULOSKELETAL				
Arthritis	☐	☐	☐	☐
Swollen or painful joints	☐	☐	☐	☐
Bursitis or tendinitis	☐	☐	☐	☐
Back pain	☐	☐	☐	☐
Back surgery	☐	☐	☐	☐
"Trick" or lock knee	☐	☐	☐	☐
Knee surgery	☐	☐	☐	☐
Painful or "trick" shoulder	☐	☐	☐	☐
Chiropractic treatments	☐	☐	☐	☐
Persistent or severe muscle aches or pains If so where:	☐	☐	☐	☐
Other musculoskeletal conditions Please list:				
ENDOCRINE/METABOLIC SYSTEM				
Diabetes	☐	☐	☐	☐
Thyroid condition or disease	☐	☐	☐	☐
Hypoglycemia	☐	☐	☐	☐
Unexplained weight gain	☐	☐	☐	☐
Unexplained weight loss	☐	☐	☐	☐
Gout	☐	☐	☐	☐
Osteoporosis or other bone disease	☐	☐	☐	☐
Other condition of the endocrine system Please list:				
BLOOD/LYMPH SYSTEM				
Anemia	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐
Sickle cell disease or trait	☐	☐	☐	☐
Phlebitis/blood clotting disorder	☐	☐	☐	☐
Blood transfusion	☐	☐	☐	☐
Chills, fever or night sweats	☐	☐	☐	☐
Swelling of lymph nodes that doesn't go away	☐	☐	☐	☐
Other blood or lymph conditions Please list:				

HEALTH CONDITION	NEVER HAD	PREVIOUSLY HAD	NOW HAVE	DON'T KNOW
SKIN				
Dermatitis or eczema	☐	☐	☐	☐
Hives	☐	☐	☐	☐
Moles that bleed or get larger	☐	☐	☐	☐
Change in color of skin (other than suntan)	☐	☐	☐	☐
Frequent boils/abscesses	☐	☐	☐	☐
Acne	☐	☐	☐	☐
Trouble with fingernails	☐	☐	☐	☐
Small itching blisters on the sides of your fingers or palms of hands	☐	☐	☐	☐
Sores that do not heal	☐	☐	☐	☐
Other skin conditions Please list:				
ALLERGIES (caused by)				
Food	☐	☐	☐	☐
Soaps and/or detergents	☐	☐	☐	☐
Metals, chromium	☐	☐	☐	☐
Nickel	☐	☐	☐	☐
Rubber	☐	☐	☐	☐
Epoxy resin	☐	☐	☐	☐
Plants (e.g., poison ivy, etc.)	☐	☐	☐	☐
Pollen	☐	☐	☐	☐
Insect scales	☐	☐	☐	☐
Bee stings	☐	☐	☐	☐
Animal dander (cats, dogs, etc.)	☐	☐	☐	☐
House dust	☐	☐	☐	☐
Industrial chemicals	☐	☐	☐	☐
Other allergies Please list				
INFECTIOUS OR CHILDHOOD DISEASES				
Meningitis/encephalitis	☐	☐	☐	☐
Polio	☐	☐	☐	☐
Rheumatic fever	☐	☐	☐	☐
Mumps	☐	☐	☐	☐
Measles	☐	☐	☐	☐
Venereal disease	☐	☐	☐	☐

IMMUNIZATION STATUS

TEST OR IMMUNIZATION FOR:	EVER RECEIVED? YES	NO	DON'T KNOW	LAST RECEIVED YEAR	DON'T KNOW
Gamma globulin	☐	☐	☐		☐
Hepatitis B	☐	☐	☐		☐
Influenza	☐	☐	☐		☐
Polio	☐	☐	☐		☐
Rubella (measles)	☐	☐	☐		☐
Smallpox	☐	☐	☐		☐
Tetanus	☐	☐	☐		☐
TB test	☐	☐	☐		☐
Other immunization or tests Please list:					

MEDICATION HISTORY

MEIDCATION NAME	Now taking Yes	No	Taken in last year Yes	No	Allergic to Yes	Unsure
Anesthetics (e.g., Novocain)	☐	☐	☐	☐	☐	☐
Antacids	☐	☐	☐	☐	☐	☐
Anticoagulants	☐	☐	☐	☐	☐	☐
Arthritis medicines	☐	☐	☐	☐	☐	☐
Aspirin or aspirin substitutes	☐	☐	☐	☐	☐	☐
Asthma medicines	☐	☐	☐	☐	☐	☐
Birth control pills	☐	☐	☐	☐	☐	☐
Blood pressure medicine	☐	☐	☐	☐	☐	☐
Cold medicines	☐	☐	☐	☐	☐	☐
Cortisone or other steroids	☐	☐	☐	☐	☐	☐
Dexedrine	☐	☐	☐	☐	☐	☐
Diet pills	☐	☐	☐	☐	☐	☐
Digitalis or other heart pills	☐	☐	☐	☐	☐	☐
Diuretics/water pills	☐	☐	☐	☐	☐	☐
Hormones	☐	☐	☐	☐	☐	☐
Insulin	☐	☐	☐	☐	☐	☐
Laxatives	☐	☐	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐	☐	☐
Methadone	☐	☐	☐	☐	☐	☐
Pain medicine (e.g., codeine, etc.)	☐	☐	☐	☐	☐	☐
Penicillin	☐	☐	☐	☐	☐	☐
Other antibiotics	☐	☐	☐	☐	☐	☐
Sleeping pills	☐	☐	☐	☐	☐	☐
Stimulants/caffeine	☐	☐	☐	☐	☐	☐
Tetanus anti-toxin	☐	☐	☐	☐	☐	☐
Tranquilizers/sedatives	☐	☐	☐	☐	☐	☐
Vitamins	☐	☐	☐	☐	☐	☐
Other medications Please list						

Name _____

1. MEDICAL HISTORY (Continued)

b. **Surgical History**

1. Have you ever had surgery? ☐ yes ☐ No
if yes,

	TYPE OF SURGERY	YEAR	NAME OF SURGEON	LOCATION OF HOSPITAL	COMPLICATIONS, IF ANY
2.					
3.					
4.					

c. **Hospitalization History**

1. Have you ever been hospitalized? ☐ yes ☐ no

If yes, complete the following information about hospitalization.

	PART OF BODY AFFECTED	NATURE OF ILLNESS OR REASON FOR HOSPITALIZATION	DATE (MO/YR)	WORK RELATED? Y/N	IF YES, EMPLOYER NAME
2.					
3.					

d. OTHER

1.	Have you ever been denied life or health insurance or offered it only at additional rates?	☐ yes	☐ no
2.	Have you ever been denied employment for health reasons?	☐ yes	☐ no
3.	Have you ever been disqualified for entry into or discharged from the Armed Services for medical reasons?	☐ yes	☐ no
4.	Have you ever received, is there pending, have you applied for or do you intend to apply for a pension or compensation?	☐ yes	☐ no
5.	Have you ever had to change jobs for health reasons?	☐ yes	☐ no
6.	Do you currently have any health condition that may limit your performance of any type of task or job?	☐ yes	☐ no
7.	Are you currently partially disabled or impaired in any way other than corrected vision?	☐ yes	☐ no
8.	Are you currently under treatment or observation for any physical or mental health condition?	☐ yes	☐ no
9.	Have you ever received disability compensation from the Armed Services?	☐ yes	☐ no
10.	Have you ever received a disability retirement from a civilian job?	☐ yes	☐ no

If any of the above questions were answered yes please explain:

Name _____

2. FAMILY HISTORY

HEALTH CONDITION OR DISEASE	TYPE OF RELATIVE															
	Mother		Father		Paternal Grandmother		Maternal Grandmother		Paternal Grandfather		Maternal Grandfather		Brothers or Sisters		Natural Children (born alive)	
	Died of	History of	Died of	History of	Died of	History of	Died of	History of	Died of	History of	Died of	History of	Died of	History of	Died of	History of
1. Heart attack or heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
2. High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
3. Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
4. Lung disease or respiratory condition	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5. Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6. Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
7.Severe loss of hearing before age 50	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
8. Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
9. Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
10. Thyroid disease or condition	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
11. Ulcers or other stomach and intestinal condition	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
12. Liver or gallbladder disease/condition	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
13. Kidney disease/condition	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
14. Convulsions/epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
15. Blood or lymph disease or condition	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
16. Rheumatism/arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
17. Mental condition, nervous breakdown, suicide	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18. Serious accident	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19. Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20. Age now or at death																

3. SOCIAL HISTORY

1. Do you smoke cigarettes? ☐ yes ☐ no
2. Have you ever smoked cigarettes in the past? ☐ yes ☐ no
3. If you now smoke, or have smoked in the past, how many years total have you smoked? _____ years
4. If you now smoke, or have smoked in the past how many packs per day do/did you smoke on average? (Choose the closest answer)

   ☐ Less than one-half (1/2) ☐ One (1) ☐ One and one-half (1 ½) ☐ Two (2)

   ☐ Two and one-half (2 ½) ☐ Three (3) ☐ More than three (3+)
5. Do you regularly drink alcoholic beverages? ☐ yes ☐ no
6. If yes, how many drinks, beers or glasses of wine do you drink daily?

   ☐ Less than 1 ☐ 1-2 ☐ 3-4

   ☐ 5-6 ☐ 7-8 ☐ More than 8
7. Do you exercise strenuously for at least 30 minutes:

   ☐ Daily ☐ Three times a week ☐ once a week

   ☐ Rarely ☐ Never
8. Do you feel frustrated, stressed or uptight?

   ☐ Daily ☐ Three times a week ☐ once a week

   ☐ Rarely ☐ Never
9. Do you eat fatty or greasy foods?

   ☐ Daily ☐ Three times a week ☐ once a week

   ☐ Rarely ☐ Never

Name _____

PHYSICIAN COMMENTS

Name _____