*TruCare Medical Center*

2290 McDaniel St., Ste. 2A
North Las Vegas, NV 89030
**Tel: (702) 657-6365**

NAME: ____________________________________ DOB: _______________

*Thank you for choosing TruCare Medical Center. Please take a few minutes to provide us with vital health information to better assist you.*

**General History:**

NO KNOWN DRUG ALLERGIES: ☐

I am allergic to: ✓ check those that apply

| Penicillin | Aspirin | NSAIDs |
|---|---|---|
| Sulfonamides | Codeine | Iodine |
| IV dye | Latex | Eggs |
| | | |

Past Medical History: ✓ check those that apply

| | self | mother | father | brother | sister |
|---|---|---|---|---|---|
| High blood pressure | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart disease | ☐ | ☐ | ☐ | ☐ | ☐ |
| High cholesterol | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart attack (MI) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ |
| Type of cancer: | ________ | ________ | ________ | ________ | ________ |
| Migraines | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes-Juvenile (Type I) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes- Adult-onset (Type II) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hyperthyroidism | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hypothyroidism | ☐ | ☐ | ☐ | ☐ | ☐ |
| Hepatitis (A) / (B) / (C) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney/Renal | ☐ | ☐ | ☐ | ☐ | ☐ |
| Gallbladder | ☐ | ☐ | ☐ | ☐ | ☐ |
| Depression | ☐ | ☐ | ☐ | ☐ | ☐ |
| Anxiety | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ |
| Emphysema/COPD | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tuberculosis (TB) | ☐ | ☐ | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ | ☐ | ☐ |

Dizzy spells/fainting/passing out? YES NO
Have you had any sexually transmitted diseases? YES NO
Are you experiencing any trouble with sexual functioning? YES NO

**PLEASE COMPLETE BOTH SIDES OF THE FORM!**



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Have you **lost** 10lbs or more in the past three (3) months YES NO
Have you **gained** 10lbs or more in the past three (3) months YES NO
Have you ever received a blood transfusion? YES NO
Have you ever had any surgeries? Explain_______________________________________________
_____________________________________________________________________________
Please tell us about any other hospitalizations or injuries:
_____________________________________________________________________________
_____________________________________________________________________________

**Social History**

Do you smoke tobacco products? Cigarettes, e-cigs, pipes, cigars, chewing tobacco, other__________
Qty _______ sticks / packs per day. For how long? ____________ Would you like help to stop? _______
Have you ever used/abused: Alcohol / Cocaine / Marijuana / Heroin / Methamphetamine / PCP

**Wellness**

**When was your last:** Enter date

| | | | |
|---|---|---|---|
| Mammogram | (females) | ________________________ | Normal /Abnormal |
| Pap smear | (females) | ________________________ | Normal /Abnormal |
| Prostate exam | (males) | ________________________ | Normal /Abnormal |
| DEXA scan | | ________________________ | Normal /Abnormal |
| Last 'flu shot? | | ________________________ | |
| Last pneumonia shot? | | ________________________ | |
| How often do you exercise? | | ____________________________________________________ | |

**Have you experienced any of the following**?

| | | |
|---|---|---|
| Chest pain | YES | NO |
| Change in vision | YES | NO |
| Change in hearing | YES | NO |
| Change in bowel habits | YES | NO |
| Do you have difficulty sleeping | YES | NO |

**For females-Gynecological History:**

How many pregnancies have you had? ______ How many children? __________
When was your last menstrual period (LMP)? _____________________________
What is the average # of days your periods last? ___________________________
How frequently do you have periods (Are they regular)? _____________________
Do you have bleeding between periods? YES NO
At what age did you start having periods? _______________
Are you now menopausal? YES NO
At what age did you stop having periods? ______________________________
Have you had a hysterectomy? Partial or total? What was the reason and when was it?
______________________________________________________________________
Do you have breast implants? (answer required for MRIs) YES NO

**PATIENT/GUARDIAN SIGNATURE: ___________________________** **DATE: ___/____/____**

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