

Wakulla Urgent Care & Diagnostic Center
2615 Crawfordville Highway, #103, Crawfordville, FL 32327
David Keen, M.D.

Mini Health Screening

Patient Name: _____ Today's Date: _____

Age: _____ Birth Date: _____

Our healthcare provider **MUST** know about your current and past health care. Completing this short form will speed up your visit, decrease the cost of your visit, and improve the quality of your care. Your Cooperation is appreciated.

Today I have:

GENERAL:

- Chills
- Fever
- Dizziness
- Body aches
- No energy, feel awful all over
- Unusual sweating

HEENT:

- Hoarseness
- Sinus pressure or pain
- Red eyes
- Runny nose
- Stuffy nose
- Nosebleeds
- Earache
- Hearing sounds like fish bowl on head
- Ear discharge
- Ringing in ears
- Loss of hearing
- Bleeding gums
- Sore throat
- Swollen glands

SKIN:

- Itching
- Rash
- Hives
- Open sores
- Red lines on skin
- Cut

HEART:

- Chest pain
- Chest pressure or heaviness
- Too fast heart beat
- Too slow heart beat
- Swelling feet or ankle
- Poor blood flow

BLADDER:

- Blood in urine
- Burning on urination
- Frequent urination
- Urgent urination (got to go NOW)
- Trouble starting to urinate
- Leaking urine
- Can not empty bladder completely

NEUROLOGICAL:

- Ringing in ears
- Headache
- Blurred vision
- Fainting
- Flashing lights
- Numbness
- Zig zag lines in front of eyes
- Halos around lights
- Double vision

LUNGS:

- Cough - nothing comes up
- Chest hurts with cough
- Cough - stuff comes up
- Wheezing
- Short of breath
- Unable to lay flat and breath
- Cough all night & can not sleep

MUSCLES:

- Back ache
- Muscle pain
- Muscle weakness
- Joint pain
- Joint swelling
- Joint injury – which _____

GASTROINTESTINAL:

- Poor appetite
- Constipation
- Diarrhea
- Indigestion
- Feel like you need to throw-up
- Throwing up
- Throwing up blood
- Stomach ache
- Difficulty swallowing
- Cramping
- Abdominal pain

REPRODUCTIVE: (male & female)

- Vaginal bleeding
- Vaginal discharge
- Vaginal odor
- Vaginal itching
- Penis discharge
- Blisters in area
- Sores in area
- Warts or dots in area

Wakulla Urgent Care & Diagnostic Center
2615 Crawfordville Highway, #103, Crawfordville, FL 32327
David Keen, M.D.

Patient Name: _____

I have these illnesses:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anorexia-bulimia |
| <input type="checkbox"/> Arthritis – old age | <input type="checkbox"/> Arthritis – rheumatoid | <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic bronchitis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Diabetes – as child |
| <input type="checkbox"/> Diabetes- adult | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Seizures | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Gouty arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Hepatitis: _____ | <input type="checkbox"/> Herpes simplex | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> HIV positive |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Kidney failure – end stage renal disease | |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Stroke | <input type="checkbox"/> Low thyroid |
| <input type="checkbox"/> High thyroid | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Positive PPD test | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Enlarged prostate | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety disorder |
| <input type="checkbox"/> Panic attack | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Bipolar disease | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Sexually transmitted disease (s): _____ | <input type="checkbox"/> Others: _____ | | |

My mother, father, brother(s) and sister(s) had or have:

- | | | | |
|--|---|---------------------------------------|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Asthma | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Cancer – type _____ | | | |

I have had the following surgeries:

Surgery	Where	Date

I have had the following serious illnesses or was in the hospital for (other than surgery):

Illness or reason	Where	Date

Pregnancies:

Child's sex/miscarriage/abortion	Date	Complications

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform the health care providers at this clinic if I, or my minor child, ever have a change in health.

Signature

Date

Print Your Name

Date