Wakulla Urgent Care & Diagnostic Center
41 Feli Way, Crawfordville, FL 32327-2368
David A. Keen, MD & Valerie M. Russell, ARNP

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

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Patient Name:____

I have these illnesses:

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

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

( ) Arthritis
( ) Gout
( ) Asthma
( ) Allergies
( ) Alcoholism
( ) Drug abuse
( ) Diabetes
( ) Heart disease
( ) Strokes
( ) Kidney disease
( ) Tuberculosis
( ) High blood pressure
( ) 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