UNIVERSITY OF SOUTH CAROLINA
SCHOOL OF MEDICINE
UNIVERSITY SPECIALTY CLINICS®

Medical Information Database

Name: _____ Date: _____

Reason for seeing doctor: _____
Referring Physician: _____
Were you seen in the Emergency Room? YES NO
___ Richland ___ Baptist ___ Lexington ___ Providence ___ Providence NE
___ Other
Date of accident or injury: _____
If not accident or injury, date the symptoms began: _____
Current physician, pediatrician, or family doctor, if you have one: _____

Previous Medical History

List all known allergies: _____
_____
Do you have a Latex Allergy/Sensitivity? YES NO
List all medications you are taking and reason you are taking it (including Aspirin, Ibuprofen, Motrin, NSAID, Goody Powder, Vitamins, herbal Medication, etc.): _____
_____
_____
_____
List any medications that you cannot take: _____
_____

Immunizations

Please indicate date (month and year) of last immunization.

Tetanus Booster _____ Chicken Pox _____
DPT _____ Hepatitis B _____
MMR _____ Polio _____

Patient Name: _____ Date: _____

Current Medical Problems

Please "X" YES or NO

YES	NO		YES	NO	
___	___	High Blood Pressure	___	___	Cardiac Disease/Heart Attack
___	___	Cancer	___	___	Diabetes
___	___	Immune Deficiency	___	___	Kidney Disease
___	___	Lung Disease	___	___	Substance Abuse
___	___	HIV/AIDS	___	___	Hepatitis A / B / C
___	___	Breast Disease			
___	___	Other, if any please explain: _____			

Review of Systems

Please "X" YES or NO

YES	NO		YES	NO	
___	___	Fever	___	___	Vision Problem
___	___	Sinusitis	___	___	Chest Pain
___	___	Seizures	___	___	Constipation
___	___	Skin lesions that are changing	___	___	Coughing up blood
___	___	Excessive bleeding	___	___	Chills
___	___	Glasses	___	___	Sore throat
___	___	Shortness of breath	___	___	Weakness or numbness
___	___	Diarrhea	___	___	Blood in urine
___	___	Jaundice	___	___	Weight loss or gain
___	___	Ear aches	___	___	Wheezing/Asthma
___	___	Heartburn	___	___	Fainting
___	___	Blood in bowel movements	___	___	Difficulty urinating
___	___	Depression or anxiety	___	___	Difficulty healing wounds

Previous Hospitalizations

Date Month and Year	Reason for Hospitalization
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name: _____ Date: _____

Past Surgical History

Date Month and Year	Procedure	Difficulty with Anesthesia
_____	_____	YES / NO
_____	_____	YES / NO
_____	_____	YES / NO
_____	_____	YES / NO
_____	_____	YES / NO
_____	_____	YES / NO

Social History

Do you use tobacco products of any kind? YES / NO Amount / Frequency: _____
Do you drink alcohol? YES / NO Amount / Frequency: _____
Do you use illegal drugs? YES / NO Amount / Frequency: _____
Occupation: _____
Living Situation: _____

Family History

Please "X" YES or NO and relationship

	YES	**NO**	**Relationship**
High Blood Pressure	____	____	_____
Diabetes	____	____	_____
Breast Cancer	____	____	_____
Melanoma	____	____	_____
Other Cancers	____	____	_____

Reviewed on _____ By _____

Reviewed and updated on _____ By _____

Reviewed and updated on _____ By _____