



Matthews Free Medical Clinic

Matthews Free Medical Clinic

Date \_\_\_/\_\_\_/\_\_\_

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Age

\_\_\_\_\_  
Birth Date (mm/dd/yy)

CIRCLE: Male Female

\_\_\_\_\_  
Race

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State Zip Code

(\_\_\_\_) \_\_\_\_\_  
Home Phone

(\_\_\_\_) \_\_\_\_\_  
Cell Phone

\_\_\_\_\_  
Language

\_\_\_\_\_  
Need Interpreter?: Y / N

Why do you want to see a doctor?:

\_\_\_\_\_  
\_\_\_\_\_

Please circle all that apply:

Are you a U.S. Citizen? Y N

Are you a U.S. Resident? Y N

LIST ALL MEDICATIONS CURRENTLY TAKING:

Name of Medication (s):	Strength(mg):	How often:

Do you currently have health insurance? Y N

Do you have Medicaid? Y N

Are you pregnant? Y N

Do you smoke? Y N

Do you drink alcohol? Y N

Do you use street drues? Y N

Pharmacy Name & Phone#: \_\_\_\_\_

Do you work?: \_\_\_\_\_

If yes, where?: \_\_\_\_\_

List Allergies: \_\_\_\_\_

List past surgeries, hospitalizations, and or other problems:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Contact Information:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relation

(\_\_\_\_) \_\_\_\_\_

Phone Number

SIGNATURE \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_

Matthews Free Medical Clinic

Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_

Birth Date (mm/dd/yy) \_\_\_\_\_

Age \_\_\_\_\_

PERSONAL HEALTH HISTORY- CIRCLE THE FOLLOWING PROBLEMS

Heart	Lungs	Gastrointestinal	Genitourinary	Miscellaneous
Heart attack	Shortness of Breath	Nausea/Vomiting	Bladder Infection	Weight Loss
Chest Pain	Pneumonia	Diarrhea	Bloody Urine	Weight Gain
High Blood Pressure	Asthma	Constipation	Frequent Urination	Back Pain
Other:	Cough	Ulcers	Urinating multiple times a night	Sciatica
	Other:	Gall Bladder	Other:	Arthritis
		Heartburn		Headaches
<b>Endocrine</b>		Bloody Stool		Seizures
Diabetes		Black Tarry Stool		Osteoporosis
Thyroid		Abdominal Pain		Cancer
Other:		Spastic Colon		Depression
		Other:		Mental Illness
				Menstrual Problems
				Anemia
				Skin Problems
				Alcohol/Drug Addiction

Family History: Circle If Occurred in Close Family Member and State Which Family Member

	Family Member		Family Member
Cancer		Hypertension	
Stroke		Diabetes	
Thyroid		High Cholesterol	
Heart Trouble		Other:	