



ALASKA MEDICAL CLINICS, LLC

DIMOND MEDICAL CLINIC
LAKE OTIS MEDICAL CLINIC
WASILLA MEDICAL CLINIC

MEDICAL RECORD

REPORT OF MEDICAL HISTORY

DATE OF EXAM: _____

NOTE: This information is for official and medically confidential use only and will not be released to unauthorized persons.

1. NAME OF PATIENT <i>(Last, first, middle)</i>			
4a. HOME ADDRESS			
4b. CITY	4c. STATE	4d. ZIP CODE	

6. PURPOSE OF EXAMINATION

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Use additional pages if necessary)*

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
c. ALLERGIES <i>(Include insect bites/stings and common foods)</i>		
	d. HEIGHT	e. WEIGHT
8. PATIENT'S OCCUPATION		9. ARE YOU <i>(Check one)</i> <input type="checkbox"/> RIGHT HANDED <input type="checkbox"/> LEFT HANDED

10. PAST/CURRENT MEDICAL HISTORY

CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW	CHECK EACH ITEM	YES	NO	DON'T KNOW
Household contact with anyone with tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone, joint or other deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or positive TB test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or pressure in chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of finger or toe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in sputum or when coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful or "trick" shoulder or elbow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excessive bleeding after injury or dental work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation or pounding heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent back pain or any back injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide attempt or plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Trick" or locked knee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleepwalking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear corrective lenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps in your legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nerve injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye surgery to correct vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (including infantile)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lack vision in either eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver, or intestinal trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear a hearing aid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble or gallstones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Car, train, sea or air sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stutter or stammer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear a brace or back support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or excessive worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adverse reaction to medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory or amnesia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin diseases	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous trouble of any sort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen or painful joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, growth, cyst, cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Periods of unconsciousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parent/sibling with diabetes, cancer, stroke or heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids or rectal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X-ray or other radiation therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting since age 12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asbestos or toxic chemical exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone or blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plate, pin or rod in any bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic or frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar or albumin in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easy fatigability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Severe tooth or gum trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been told to cut down or criticized for alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent gain or loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Used illegal substances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever or allergic rhinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder (anorexia, bulimia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Used tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism or Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble or goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
11. FEMALES ONLY											
CHECK EACH ITEM	YES	NO	DON'T KNOW	DATE OF LAST MENSTRUAL PERIOD	DATE OF LAST PAP SMEAR			DATE OF LAST MAMMOGRAM			
Treated for a female disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Change in menstrual pattern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
CHECK EACH ITEM, IF "YES" EXPLAIN IN BLANK SPACE TO RIGHT. LIST EXPLANATION BY ITEM NUMBER											
ITEM	YES	NO									
12. Have you been refused employment or been unable to hold a job or stay in school because of	<input type="checkbox"/>	<input type="checkbox"/>									
a. Sensitivity to chemicals, dust, sunlight, etc.	<input type="checkbox"/>	<input type="checkbox"/>									
b. Inability to perform certain motions.	<input type="checkbox"/>	<input type="checkbox"/>									
c. Inability to assume certain positions.	<input type="checkbox"/>	<input type="checkbox"/>									
d. Other medical reasons <i>(if yes, give reasons)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
13. Have you ever been treated for a mental condition? <i>(If yes, specify when, where, and give details.)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
14. Have you ever been denied life insurance? <i>(If yes, state reason and give details.)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
15. Have you had, or have you been advised to have, any operation? <i>(If yes, describe and give age at which occurred.)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
16. Have you ever been a patient in any type of hospital? <i>(If yes, specify when, where, why, and name of doctor and complete address of hospital.)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? <i>(If yes, give complete address of doctor, hospital, clinic, and details.)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
18. Have you ever been rejected for military service because of physical, mental, or other reasons? <i>(If yes, give date and reason for rejection.)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
19. Have you ever been discharged from military service because of physical, mental, or other reasons? <i>(If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? <i>(If yes, specify what kind, granted by whom, and what amount, when, why)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
21. Have you ever been arrested or convicted of a crime, other than minor traffic violations. <i>(If yes, provide details.)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
22. Have you ever been diagnosed with a learning disability? <i>(If yes, give type, where, and how diagnosed.)</i>	<input type="checkbox"/>	<input type="checkbox"/>									
23. LIST ALL IMMUNIZATIONS RECEIVED											
I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinic mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service. I understand the falsification of information on Government forms is punishable by fine and/or imprisonment.											
24a. TYPED OR PRINTED NAME OF EXAMINEE				24b. SIGNATURE				24c. DATE			
NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."											
25. PHYSICIAN'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA <i>(Physician shall comment on all positive answers in items 7 through 11. Physician may develop by interview any additional medical history deemed important, and record any significant findings here.)</i>											
26a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER				26b. SIGNATURE				26c. DATE			