HEALTH HISTORY FORM

Stat Care

Urgent Care Clinic

Patient Name:_____D.O.B:_____ Date:_____

MEDICAL HISTORY: <u>CIRCLE</u> any of the following medical problems you have or may have had:

- Alcohol Abuse
- Anemia – Type_____
- Arthritis—Type_____
- Asthma
- Autoimmune disorder—Type_____
- Blood clots
- Cancer—Type:_____
  *Currently receiving chemo or radiation?-Yes / No
- Chronic diarrhea or constipation
- Chronic Obstructive Pulmonary Disease (COPD)
  *Type: Chronic Bronchitis /Emphysema
- Chronic pain – Type_____
- Crohn's Disease
- Depression/Anxiety
- Diabetes—Do you use: Insulin / Pills / Both
- Diverticulosis/Diverticulitis
- Drug Abuse
- Ear or hearing problems:_____
- Eating Disorder – Type_____
- Eye or vision problems:_____
- Fibromyalgia
- Gall bladder problems
- Heart Attack
- Heart Disease
- High blood pressure
- High Cholesterol
- HIV/AIDS
- Hypoglycemia (low blood sugar)
- Kidney disease/failure:_____
- Liver Problems—Type:_____
- Menopause
- Psychiatric Disorder—Type:_____
- Seizures/Epilepsy
- Sexually Transmitted Diseases—Type:_____
- Skin problems – Type :_____
- Stroke/TIA (mini-strokes)_____
- Thyroid problem: Hyper ↑ / Hypo ↓ / Cancer / Other
- Tuberculosis
- Ulcer/Heartburn
- Ulcerative Colitis
- Urine infections
- Other:_____

HOSPITALIZATIONS AND/OR SURGERIES: List ALL surgeries/hospitalizations that you have had

Type of surgery/Reason for hospitalization	Date

ALLERGIES/SENSITIVITIES: List ALL medications/foods that you are allergic or sensitive to

Name of medication or food	Type of reaction

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IMMUNIZATIONS: <u>CIRCLE</u> ALL that applies

Up to Date / Out of Date: Influenza--Pneumonia--Shingles--Hepatitis. Date of last tetanus shot: _____

SOCIAL HISTORY<u>: CIRCLE</u> ALL that applies

Do you use tobacco? NEVER / QUIT / smoke _____cigarettes/pack per day for _____yrs. / Dip / Chew

Do you consume alcohol? Never / Rarely / Special occasions only / Daily / Weekly

MEDICATIONS/SUPPLEMENTS: List ALL medications/supplements you are currently taking

Name	Dose	Frequency (Daily, Weekly, Etc.)

FEMALE PATIENTS

Are you or could you be pregnant? YES / NO Date of the FIRST DAY of your last menstrual period_____

Name of the pharmacy used most often/pharmacy of choice:_____

Name of your primary healthcare provider / family doctor:_____

_____ _____

Signature of patient/Legal guardian Date

_____ _____

Printed name of patient/Legal guardian Relationship to patient