URGENT CARE PAST HISTORY FORM

Date: / / MRN#

Last Name:	First Name:	DOB:	Sex: M F
Presenting Problem:			
Is this related to an Injury? No Yes -- If Yes, how did injury occur?			

Yes -- How did Injury Occur?
What were you doing when Injured?
Location where injury occurred?

Medical History

Personal		Family			Personal		Family		
Y	N	Y	N	High Blood Pressure	Y	N	Y	N	Gastrointestinal Problems
Y	N	Y	N	Diabetes	Y	N	Y	N	Thyroid Problems
Y	N	Y	N	Ulcers	Y	N	Y	N	Asthma
Y	N	Y	N	Heart Murmur/Valve Disorder	Y	N	Y	N	COPD
Y	N	Y	N	Stroke	Y	N	Y	N	Alcohol/Drug Abuse
Y	N	Y	N	Heart Attack	Y	N	Y	N	Smoker; if so # of packs/day ____
Y	N	Y	N	Cancer	Y	N	Y	N	Depression
Y	N	Y	N	Gall Stones	Y	N	Y	N	Anxiety
Y	N	Y	N	Kidney Stones	Y	N	Y	N	Other:
Y	N	Y	N	Blood Transfusions	Y	N	Y	N	
Y	N	Y	N	Immunological Disorder	Y	N	Y	N	

Medications:

Please list names and dosages, including over the counter medications & supplements. NONE

Name of Medication	Dosage/Frequency	Name of Medication	Dosage/Frequency

Allergies:

Please list any medications and/or other allergies & the reaction.

Name of Medication	Reaction	Name of Medication	Reaction

Reviewed by: ____ **on** _________________________