EAST SIDE URGENT CARE – MEDICAL HISTORY FORM

TODAY'S DATE __/____/____

NAME _____ DOB __/____/____

AGE _____ MALE FEMALE

CURRENT MEDICATIONS (list all current prescription and non-prescription medications)

_____

_____

Are you allergic to any medications? Yes No

Are you allergic to any foods? Yes No

If yes, list medication and the reaction _____

_____

Past Medical History – Please check any of the following that relate to you

Yes	No	Heart Disease/MI	Yes	No	Kidney Disease	Yes	No	Arthritis
Yes	No	High Blood Pressure	Yes	No	Kidney Stones	Yes	No	Skin Disease
Yes	No	Valve Disease	Yes	No	Thyroid Disease	Yes	No	Difficulty Urinating
Yes	No	Blood Clots	Yes	No	Glaucoma	Yes	No	Tuberculosis
Yes	No	Asthma	Yes	No	Ulcer Disease	Yes	No	Depression
Yes	No	COPD	Yes	No	Hepatitis	Yes	No	Alcohol Abuse
Yes	No	Seizures	Yes	No	Anemia	Yes	No	Drug Abuse
Yes	No	Neurological Disease	Yes	No	Cancer	Yes	No	STD
Yes	No	Severe Headaches	Yes	No	Stroke	Yes	No	Gall Bladder Disease
Ye	No	Insomnia	Yes	No	Diabetes			

Please list any surgeries you have had _____

_____

Any family history of the following: Please circle

Heart Disease Diabetes Stroke Mental Illness Cancer

Social History

Current Employment _____

Do you smoke cigarettes? Yes No Alcohol (drinks per week) _____

Coffee/Tea (cups per day) _____ Exercise (times per week) _____