



Urgent Care Patients  
2019 Health History

Name \_\_\_\_\_

Time: \_\_\_\_\_

Today's Date \_\_\_\_ / \_\_\_\_ / 2019

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Gender (Circle One) M F

Allergies

Are you allergic to any medications or other substances?

No  Yes (If yes, please list below)

\_\_\_\_\_

Medications

Please list current medications including prescription, non-prescription, vitamins, allergy shots, etc.  or  Please see attached list.

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

Medical Treatments, Hospitalizations, Surgeries, etc.

Please list any times/ reasons you have been in the hospital and date. Please include surgeries (inpatient and outpatient) and pregnancies.

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

Past/Current Illnesses & Conditions

Please check all that apply (if any)...

- add/adhd
- alcohol dependence
- anemia/blood transfusion(s)
- anxiety/depression
- asthma
- anxiety
- arthritis
- cancer (type) \_\_\_\_\_
- diabetes
- emphysema or lung disease
- epilepsy/seizures/convulsions
- glaucoma
- hepatitis
- heart disease or problem
- hyper or hypothyroidism
- hypertension (high blood pressure)
- hyperlipidemia (cholesterol)
- kidney stones or disease
- leukemia
- pneumonia
- rheumatic fever
- sexually transmitted disease(s)
- stroke
- substance abuse
- tuberculosis
- ulcer(s)
- Other \_\_\_\_\_

Smoked Tobacco Use

- Current, every day
- Current, some days
- Former
- Never

Alcohol Use

- Yes
- No
- \_\_\_\_ drinks per day
- or  drink socially

Recreational Drug Use

- No
- Current
- Past

Regular Exercise

- Yes
- No
- \_\_\_\_\_ times per week
- Type \_\_\_\_\_

Seat Belt Use

- Always
- Never
- Intermittently

Screening/Immunizations

If applicable, please indicate the date last done... tetanus shot \_\_\_\_\_

Family History

Please list details below or check here...  I am adopted and/or have no knowledge of biological family history.

**Mother**

Age (if living) \_\_\_\_\_

Age (at death) \_\_\_\_\_

**State of health or cause of death**

- Diabetes
- Heart Disease
- Hypertension/High Blood Pressure
- Other \_\_\_\_\_

**Father**

Age (if living) \_\_\_\_\_

Age (at death) \_\_\_\_\_

**State of health or cause of death**

- Diabetes
- Heart Disease
- Hypertension/High Blood Pressure
- Other \_\_\_\_\_

**Siblings**

Age(s) (if living) \_\_\_\_\_

Age(s) (at death) \_\_\_\_\_

**State of health or cause of death**

- Diabetes
- Heart Disease
- Hypertension/High Blood Pressure
- Other \_\_\_\_\_



Review of Systems Date \_\_\_\_\_

Name \_\_\_\_\_

Signature \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender (Circle One) M F

Check In Time: _____ Time Put in Rack: _____ Initials: _____ <p style="text-align: right;"><i>Office Use Only</i></p>
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Reason for Today's Visit

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Females Only:

Date of Last Menstrual Period \_\_\_\_\_ or  n/a

Pregnant  yes  no

Breastfeeding  yes  no

Menopause  yes  no

Review of Body Systems  
Please check all symptoms or conditions that you are experiencing

\*\*\*TODAY ONLY\*\*\*...

General

- fever
- chills
- sweats/night sweats
- anorexia
- fatigue
- malaise
- weight loss
- daytime drowsiness
- difficulty sleeping/sleep changes

Eyes

- blurred vision
- double vision
- irritation
- discharge
- vision loss
- eye pain or injury
- light sensitivity
- cataracts
- glaucoma
- wear glasses or contacts

Ears, Nose, Mouth & Throat

- earache/ ear pain
- ear discharge
- ringing/buzzing in ears (tinnitus)
- decreased hearing
- nasal congestion/discharge
- nosebleeds/epistaxis
- sore throat
- hoarseness/voice change

- difficulty swallowing
- seasonal allergies
- dizziness or vertigo

Cardiovascular

- chest pain, pressure or tightness
- irregular heartbeat/palpitations
- racing heart
- blackouts/syncope
- shortness of breath
- swelling in extremities (edema)
- history of abnormal EKG
- history of heart murmur
- history of abnormal stress test
- history of high blood pressure (hypertension)
- history of rheumatic fever
- history of valve disease

Respiratory

- cough
- shortness of breath
- excessive sputum
- coughing up blood
- wheezing
- chronic bronchitis
- history of asthma
- history of pneumonia
- history of tuberculosis

Gastrointestinal

- nausea
- vomiting
- diarrhea
- constipation
- change in bowel habits
- abdominal/stomach pain
- black stools (melena)
- blood in stool
- rectal bleeding
- yellowing of skin (jaundice)
- difficulty swallowing
- food intolerance
- heartburn/indigestion/reflux
- hemorrhoids/rectal disease
- liver trouble or disease

Genitourinary - Female

- vaginal discharge
- involuntary loss of urine/incontinence
- painful urination
- blood in urine
- no menstruation
- heavy menstrual bleeding
- abnormal vaginal bleeding
- severe menstrual pain
- pelvic pain
- history of kidney stones

Genitourinary - Male

- painful or difficult urination
- blood in urine
- discharge
- involuntary loss of urine/incontinence
- frequent urination
- decreased sexual desire/libido
- history of kidney stones

Musculoskeletal

- back pain or injury
- joint pain
- muscle pain
- joint swelling
- neck injury or pain
- muscle cramps
- muscle weakness
- stiffness
- arthritis
- decreased range of motion
- wasting (losing muscle mass)
- history of fracture(s)

Skin

- rash
- itching
- dryness
- suspicious lesions
- change in color or size of moles
- tumor(s) or cyst(s)
- history of skin cancer
- history of severe sunburn

Neurological

- loss of strength/paralysis
- weakness
- skin tingling, prickling, burning or numbness
- seizures
- blackouts (syncope)
- tremors/convulsions/seizures
- dizziness or vertigo
- loss of balance
- loss of sensation
- fainting
- double vision
- headache

Psychiatric

- depression
- anxiety
- memory loss
- mental disturbance
- suicidal attempts/thoughts
- hallucinations
- paranoia
- insomnia (difficulty sleeping)
- panic symptoms
- have seen psychiatrist/psychologist/counselor
- prior psych hospitalizations

Endocrine

- intolerance to cold
- intolerance to heat
- increased thirst
- excessive thirst
- frequent urination
- weight change
- changes in hair
- changes in skin
- fatigue
- weakness

Hematologic/Lymphatic

- abnormal bruising
- bleeding
- swollen/enlarged lymph nodes
- history of anemia

Allergic/Immunologic

- hives (urticaria)
- hay fever/seasonal allergies
- persistent infections
- itchy eyes
- stuffy nose (rhinitis)

Reviewed by \_\_\_\_\_

(Provider's Signature)

Date \_\_\_\_\_