

Dr. Jon's Urgent Care Center

Patient History Form

(office use only)

Welcome to Dr. Jon's Urgent Care Center! In order to provide you with the best medical care, we need to know more about you. Please answer the following questions. All answers will be recorded in your chart and are confidential. You may write on the back of this paper if you need more space:

Patient's name _____ Date of birth _____

Does the patient have any of these conditions? (Write next to "Other" any conditions not on the list.)

- | | | |
|---|---|---|
| <input type="checkbox"/> Blood from stomach or bowels | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> PE (blood clot in lungs) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Reflux/GERD |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stomach ulcer |
| <input type="checkbox"/> COPD | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer (what kind? _____) | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other (_____) |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Hyper ("high") thyroid | <input type="checkbox"/> Other (_____) |
| <input type="checkbox"/> DVT (blood clot in legs) | <input type="checkbox"/> Hypo ("low") thyroid | <input type="checkbox"/> Other (_____) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other (_____) |

What medication(s) does the patient take?

What operations has the patient had? _____

What is the patient allergic to, and what happens if he or she takes that medicine:

List any medical or psychiatric problems the patient's family members have:

Mother _____
Father _____
Sisters _____
Brothers _____
Other _____

Patient's social history:

Marital status _____ Who do you live with? _____
Are you employed? _____ Occupation _____
What kind of tobacco do you use? _____ How much? _____ For how long? _____
Are you a former tobacco user? _____ When did you quit? _____ Does anyone smoke inside your house? _____
Do you drink alcohol? ___None ___Occasionally ___Moderate ___Heavy How much? _____
Do you use any street drugs? _____ What are they? _____

Is there anything else we need to know to take better care of you? _____
