Dr Jon
Urgent Care Center

(Office Use Only)

Patient History Form

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)

___Blood from stomach or bowels
___Anxiety disorder
___Arthritis
___Asthma
___COPD
___Cancer (what kind? _____)
___Coronary Artery Disease
___DVT (Blood Clot in Legs)
___Depression
___Diabetes
___Fibromyalgia
___Gout
___Heart Disease
___High Cholesterol
___ High Blood Pressure
___hyper ("high") Thyroid
___Hypo ("Low") Thyroid
___Kidney Disease
___Osteoporosis
___PE (blood clot in lungs)
___Reflux/GERD
___Stomach Ulcers
___Stroke
___ Other (_____)
___Other (_____)
___Other (_____)
___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 the medication?

_____
_____

List any medical or psychiatric problems the patient family members have:
Mother: _____
Father: _____
Sisters:

_____

Brothers: _____
Other: _____

Patient Social History

Marital Status; _____ who do you live with? _____
Are you employed? _____ Occupation: _____
What kind of tobacco do you use? _____How much? _____How Long? _____
Are you a former tobacco user: _____When did you quit? _____Does anyone in your house smoke? _____
Do you drink alcohol? ___None ____Occasionally ___Moderate ___Heavy How much do you drink? _____
Do you use any street drugs? _____ what are they? _____

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

_____