Health First
URGENT CARE

HEALTH QUESTIONNAIRE

Name: _____ **Birth Date**: ____/_____/_____ **Date**: ____/_____/_____
Last First MI

Gender: ☐ Male ☐ Female, if yes : ☐ Pregnant? ☐ Breastfeeding?

Reason for visit today? _____

List all your current medications, including non-prescription drugs: ☐ None _____

_____

Medication Allergies: ☐ No known allergies _____

PAST MEDICAL HISTORY (Check all that apply & Specify) ☐ NONE APPLY

☐ Allergies _____
☐ Anxiety_____
☐ Asthma_____
☐ Arthritis_____
☐ Cancer _____
☐ Depression_____
☐ Diabetes (type)_____
☐ Emphysema/COPD_____
☐ Epilepsy/Seizure Disorder _____
☐ Headaches_____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ High Cholesterol_____
☐ Kidney Disease_____
☐ Liver Disease_____
☐ Stroke_____
☐ Thyroid Disease_____
☐ Other (specify)_____

HOSPITALIZATION & SURGERY (Check all that apply, specify and write in date below) ☐ NONE APPLY

☐ Appendix _____
☐ Adenoids _____
☐ Back _____
☐ Breast _____
☐ Heart Surgery _____
☐ Hernia _____
☐ Hysterectomy _____
☐ Tonsillectomy _____
☐ Tubal Ligation _____
☐ Vasectomy _____
☐ C-Section _____
☐ Other (specify)_____

FAMILY HISTORY (Check all that apply & specify) ☐ NONE APPLY

☐ Asthma _____
☐ Cancer (specify) _____
☐ Dementia/Alzheimer's _____
☐ Depression _____
☐ Diabetes_____
☐ Heart Disease _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Stroke_____
☐ Thyroid Disease_____
☐ C-Section _____
☐ Other _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you smoke? ☐ No ☐ Yes _____ packs/day

Do you drink alcoholic beverages? ☐ No ☐ Yes

For the MINOR patient:

Child lives with: ☐ Parents ☐ Grandparents

☐ Other _____

Do you use any recreational drugs or medications not prescribed to you? ☐ No ☐ Yes, _____

I have read the above information and consent that it is correct to the best of my knowledge. I authorize Health First Urgent Care and its health care providers to render necessary treatment for my condition.

_____ _____
Signature of Patient/Guardian **Date**

This form has been reviewed by the treating physician:

_____ _____
Signature of Physician **Date**