Pro-Health URGENT CARE

Name: _____ DOB: _____

(please print)

Medical History: Have you ever had? Check "Y" for a yes response, "N" for a no response. Please answer all questions.

	Y	N		Y	N		Y	N
Measles			Pneumonia			Angina		
Chicken Pox			Scarlet Fever			High or Low Blood Pressure		
Bone / Joint Disease			Migraine Headache			Asthma		
Cancer			Venereal Diseases			Stroke		
Tuberculosis			Diabetes			Hernia		
Stomach Ulcers			Nervous Breakdown			Kidney Problems		
Hives / Rashes			Thyroid Problems			Back Pain		
Heart Trouble			Liver Trouble			Alcohol / Drug Problems		

Hospital Admissions: Include year you were admitted to hospital and reason.

Year	Illness or Operation	Year	Illness or Operation

Medications: List all medications that you are now taking. Include over the counter medications and herbal medications.

Name of Drug	Strength	How Often	Name of Drug	Strength	How Often
			Drug Allergies	Other Allergies	

Immunization: Please indicate the year of the last dose of each vaccine.

Tetanus / Diphtheria		Flu		Pertussis	

Menstrual History (Women Only)

Date of last period		Number of pregnancies	
Age of first period		Number of live births	

Social History: Please complete all questions.

Smoking History:		How long have you smoked?	Alcohol use: Yes / No
○	Do not smoke		
○	Quit smoking, when?	How many packs a day?	If yes, how many drinks per week?

Family History: If any blood relative has suffered from the following - please indicate which relative.

Tuberculosis		Stroke		Migraines	
Epilepsy		Diabetes		Cancer	
Arthritis		Kidney Disease		Mental Illness	
Heart Disease		High Blood Pressure			

Systems Review: Do you currently have? Check "Y" for a yes response, "N" for a no response. Please answer all questions.

	Y	N		Y	N		Y	N
Fatigue			High Blood Pressure			Eczema / Psoriasis		
Weakness			Chest Pain			Hives		
Insomnia			Irregular Heartbeat			Loss of Appetite		
Weight Loss			Joint Pain / Swelling			Trouble Swallowing		
Weight Gain			Back Pain			Nausea / Vomiting		
Headaches			Varicose Veins			Abdominal Pain		
Blurry Vision			Swollen Ankles			Change in Bowel Movement		
Double Vision			Fainting Spells			Painful / Bloody Stool		
Eye Pain			Dizziness					
Hearing Loss			Seizures			**Females**		
Ringing in Ears			Tremors			Painful Sex		
Earaches			Numbness			Vaginal Discharge		
Sore Throats			Depression			Breast Soreness / Discharge		
Hoarseness			Nervousness			Breast Lumps		
Bleeding Gums			Mental Illness			Painful Urination		
Swollen Gums			Anemia					
Chronic Cough			Easy Bruising			**Males**		
Coughing Up Blood			Cancer			Pain / Swelling of Testicles		
Shortness of Breath			Rash			Trouble Urinating		
						Penile Sores or Discharge		

I HERBY CERTIFY THAT: I have carefully read and completed the foregoing information, and that my answers and explanations are true to the best of my knowledge and belief.

Patient Signature: _____ Date: ____/____/____

Guardian or Legal Representative Signature: _____