Great Lakes Urgent Care Center PC

Adult Health History Form

NAME	DOB / /	DATE / /	RACE

What problem brings you to our clinic today and how long has it bothered you. _____

_____

_____

Current Medication (include, OTC, Herbal, Prescription) _____

_____

Drug Allergies _____

Pharmacy _____

T_____ P_____ R_____ BP_____ HEIGHT_____ WEIGHT_____

PERSONAL MEDICAL HISTORY: What are your current medical conditions

_____ Vaginal/Genital infections
_____ Genital Herpes, warts
_____ Visual Trouble
_____ Chronic Cough
_____ No Appetite
_____ Weight Loss
_____ Increased Thirst
_____ Trouble Swallowing
_____ Blood in Urine
_____ Burning with Urination
_____ Blood in Stool
_____ Dementia/Alzheimer's
_____ Diabetes
_____ Arthritis
_____ Chest Pain
_____ Shortness of Breath
_____ Hard of hearing

_____ Asthma/Lung Disease
_____ High Cholesterol
_____ Cancer
_____ Heart Fluttering
_____ Dizziness
_____ Easy Bruising
_____ Tingling/Numbness
_____ Swollen Ankles
_____ Hypertension
_____ Headaches
_____ Thyroid Disease
_____ Osteoporosis
_____ Swollen Joints
_____ Joint Pain

_____ Depression
_____ Heart Disease
_____ Kidney Disease
_____ Seizures
_____ Sore Muscles
_____ Back Pain
_____ Fever
_____ Skin Rash
_____ Voice Changes
_____ Sinus Trouble
_____ Sore Throat
_____ Ear Infections
_____ Pain
_____ Stroke
_____ Painful urination
_____ Last Tetanus

Surgeries _____

SOCIAL HISTORY

Do you smoke cigarettes Yes No Never Quit Date _____

Current Smoker: packs/day _____ # of years _____

ALCOHOL USE

Do you drink alcohol? _____ Number of drinks per week _____

DRUG USE

Do you use any recreational drugs? If yes, what kind? _____

PATIENT SIGNATURE:_____

DATE:_____ PRIMARY PHYSICIAN_____/Phone/Fax_____

REVIEWED & DISCUSSED WITH PATIENT BY:_____