ADVANCED
URGENT CARE
CENTER

PATIENT HISTORY FORM

Today's Date: _____

Name: _____

DOB: _____ Marital Status: _____

Last Medical Exam: _____

Last Doctor: _____

Females Only: _____

Last Mammogram: _____ Pap Smear: _____

Allergies: _____

_____

Medications: (list all medications including non prescription) _____

_____

_____

_____

_____

Previous Medical Illness, Surgeries, or Hospitalizations: _____

_____

_____

_____

Do you have any medical problems? _____

_____

_____

_____

_____

OB/GYN History: Pregnancies: _____ Deliveries: _____

Current Tobacco Use? # of packs per day: _____ Years? _____

Alcohol Use? _____ oz per week or number of glasses

Drug Use? _____

Family History: Check the box next to the condition that your family member has.

☐ alcoholism ☐ anemia ☐ asthma ☐ arthritis ☐ bleed easily ☐ breast cancer ☐ colon polyps
☐ colon cancer ☐ diabetes ☐ glaucoma ☐ gout ☐ heart disease ☐ high bp ☐ iron disease
☐ kidney disease ☐ mental illness ☐ migraine ☐ osteoporosis ☐ prostate cancer
☐ seizures ☐ thyroid disease ☐ tuberculosis

Immunizations: When was your last booster?

Tetanus: _____

Flu Vaccine: _____

Pneumonia: _____

Advanced Directives: Please discuss with your spouse or family and your physician.

Living Will? ☐ Yes ☐ No Organ donor? ☐ Yes ☐ No

Durable Power of Attorney for Health Care? ☐ No ☐ Yes Who? _____