

First Choice Urgent Care
Patient History Form

*Please fill out **ONLY** the portion **ABOVE** the dotted line!*

Patient's Name: _____ Today's Date: _____

Reason for visit: _____
(Please List Symptoms, i.e. cough, headache, runny nose etc.)

List ALL Medications (Including over-the-counter) (Attach list if needed)

Allergies? Y (Please List) N **Latex Allergy?** Y N

- | | | | |
|--|---|---|--------------|
| 1. Is Visit Auto Accident Related | Y | N | |
| 2. Is Visit Work Related | Y | N | |
| 3. Have you ever filed/or plan to file a lawsuit related to the visit today? | Y | N | |
| 4. Do you use Tobacco Products? | Y | N | |
| 5. Do you consume alcohol? | Y | N | Occasionally |
| 6. Females: Pregnant or Nursing?
_____ Last Menstrual Cycle | Y | N | |

*** If you answered YES to question(s) 1 or 2, please return to the front desk.**

For Physician Use Only

Patient Past Medical History

Heart Disease Stroke
Diabetes Cancer (type) _____
High Blood Pressure Other: _____

Patient Family Medical History

Diabetes
Cancer (type) _____
Stroke
Heart Disease
Other: _____

Patient Past Surgery

Appendix
Gallbladder
Heart
Hysterectomy
C-Section
Tonsil/Adenoids
Other: _____

Medic
Signature: _____

Physician
Signature: _____