Alliance URGENT + CARE

PATIENT HISTORY

Reason for today's visit?_____ Date Illness/Injury began?_____

Medication Allergies & Reaction:_____

_____

Other Allergies & Reaction:_____

Please make an (x) by any of these conditions you may have or have had in the past:

_____ Heart disease
_____High blood pressure
_____High cholesterol
_____Lung disease
_____Asthma
_____Tuberculosis/TB
_____Sleep Apnea
_____Stomach disease
_____Bowel disease
_____Liver disease
_____Kidney, bladder or prostate disease
_____Chronic skin disease
_____Joint replacement
_____Spine disorder
_____Muscle disease
_____Stroke
_____Seizures
_____Severe headaches
_____Nerve impairment
_____Anemia or other blood disorder
_____Depression
_____Mental health problems
_____Diabetes
_____Hypoglycemia
_____Thyroid disease
_____Cancer (past or present)
_____Blood clots
_____Bleeding tendency
Other:_____
_____

Current Medications – Name, dose & Frequency (Include non-prescription products)

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

Personal Habits

Do you drink caffeinated beverages (coffee, tea, soda)? _____ cups per day?_____
Do you drink alcoholic beverages?_____ If yes, _____drinks per ____day _____week _____month
Do you smoke or chew tobacco? _____If yes, _____ per day, _____years of use
If no, any prior tobacco use?_____years

Major Surgeries

Approximate Date:_____ Surgery:_____

Approximate Date:_____ Surgery:_____

Approximate Date:_____ Surgery:_____

Special Considerations

☐ Legally Blind ☐ Hearing impaired ☐ Need handicap facilities ☐ Pregnant ☐ Attempting pregnancy

☐ Alcohol abuse (describe)_____ ☐ Substance abuse (describe):_____

☐ None of the above