



HEALTH QUESTIONNAIRE

Name: _____ Birth Date: ____/____/____ Date: ____/____/____
Last First MI

Gender: [] Male [] Female, if yes : [] Pregnant? [] Breastfeeding?

Reason for visit today? _____

List all your current medications, including non-prescription drugs: [] None _____

Medication Allergies: [] No known allergies _____

PAST MEDICAL HISTORY (Check all that apply & Specify) [] NONE APPLY

- [] Allergies [] Anxiety [] Asthma [] Arthritis [] Cancer [] Depression [] Diabetes (type) [] Emphysema/COPD [] Epilepsy/Seizure Disorder [] Headaches [] Heart Disease [] High Blood Pressure [] High Cholesterol [] Kidney Disease [] Liver Disease [] Stroke [] Thyroid Disease [] Other (specify)

HOSPITALIZATION & SURGERY (Check all that apply, specify and write in date below) [] NONE APPLY

- [] Appendix [] Adenoids [] Back [] Breast [] Heart Surgery [] Hernia [] Hysterectomy [] Tonsillectomy [] Tubal Ligation [] Vasectomy [] C-Section [] Other (specify)

FAMILY HISTORY (Check all that apply & specify) [] NONE APPLY

- [] Asthma [] Cancer (specify) [] Dementia/Alzheimer's [] Depression [] Diabetes [] Heart Disease [] High Blood Pressure [] High Cholesterol [] Stroke [] Thyroid Disease [] C-Section [] Other

SOCIAL HISTORY

Marital Status: [] Single [] Married [] Divorced [] Widowed

For the MINOR patient:

Do you smoke? [] No [] Yes _____ packs/day

Child lives with: [] Parents [] Grandparents

Do you drink alcoholic beverages? [] No [] Yes

[] Other _____

Do you use any recreational drugs or medications not prescribed to you? [] No [] Yes, _____

I have read the above information and consent that it is correct to the best of my knowledge. I authorize Health First Urgent Care and its health care providers to render necessary treatment for my condition.

Signature of Patient/Guardian

Date

This form has been reviewed by the treating physician:

Signature of Physician

Date