Professional Urgent Care Services

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MEDICAL QUESTIONNAIRE – NEW PATIENT

Date of Visit_____

Patient Name: _____ Age: ____ Date of Birth: _____
Primary Care Physician: _____Physician's Phone: _____
Would you like us to fax visit report to your Primary Care Physician: Yes or No (please circle)
Chief Complaint/Reason for visit: _____

PAST MEDICAL HISTORY – Circle any of the following you currently have or have had in the past:

heart attack	asthma	diabetes
irregular heart beat	COPD/emphysema	Cancer: type _____
heart disease	chronic bronchitis	ulcers
hypertension	kidney disease	migraine headaches
vascular disease	thyroid disease	allergic rhinitis/hay fever
blood clots or bleeding problems	sleep apnea	other: _____ _____

ALLERGIES: (list drug allergies and reactions) _____
_____
_____

PAST SURGICAL HISTORY: (Please list **ALL** surgeries and dates of surgeries) _____
_____
_____

CURRENT MEDICATIONS: (including vitamins, herbals, over the counter medicines)
_____
_____

Do you consume alcohol? _____ Do you smoke? _____
Pharmacy: _____

Start Date of last menstrual cycle (Females only): _____