

# 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): \_\_\_\_\_