MOORE EXPRESS urgent care

Medical History

Patient Name: _____ **M / F** **Date of Birth:** _____

Please list all current medications and dosages (including Rx eye drops) :

_____ _____ _____

_____ _____ _____

_____ _____ _____

Drug allergies : **None** **or** **List DRUG NAME and the REACTION it causes:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Tobacco use: **Y** **N** **Type?** _____ **How much?** _____ **How long?** _____

Alcohol use: **Y** **N** **Type?** _____ **How much?** _____ **How long?** _____

Recreational drugs: **Y** **N** **Type?** _____ **How much?** _____ **How long?** _____

Women only:

Last Pap smear _____ **Last mammogram** _____ **# of pregnancies** _____

Any OB/Gyn problems _____ **Type of birth control** _____

Have you ever been treated for:

High blood pressure	Y	N	Asthma	Y	N	Depression	Y	N
Heart attack	Y	N	Allergies	Y	N	Anxiety	Y	N
Other heart disease	Y	N	Ear infections	Y	N	Stomach	Y	N
Stroke	Y	N	Hepatitis	Y	N	Intestine/Colon	Y	N
Circulation problems	Y	N	Neurologic problems	Y	N	Arthritis	Y	N
High Cholesterol	Y	N	Diabetes	Y	N	Cancer	Y	N
Emphysema	Y	N	Thyroid	Y	N	TB	Y	N
Glaucoma	Y	N	Kidney/Bladder	Y	N	Autoimmune	Y	N

Other medical problems: _____

_____

What surgeries have you had:

Tonsils Adenoids Ear tubes Appendix Gall bladder Thyroid Sinuses Hysterectomy Tubal lig. Open Heart Heart Stents Cataracts

Other surgeries: _____

_____

_____

Any medical problems that run in the family: _____

_____

_____

_____

Your regular doctor (PCP) is: _____

_____

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