First Med
URGENT CARE

PATIENT HISTORY QUESTIONNAIRE

LAST NAME | **FIRST NAME** | **MIDDLE INITIAL**

DATE OF BIRTH **SEX M F**

List any allergies you have including medications, food or any other negative reaction and type of reaction.

○ **NKDA** (no known drug allergies)

Allergies: _____

List all long term or recurring medical problems and any medications you are currently taking, including over the counter medication. Please list medication strength and how often you take the medication.

Please Note: ***If you do not know the medication, please call your pharmacy. We are unable to provide care without a current medication list.***

List all medications currently taking, including over the counter medications.

○ **NONE**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List all long term or recurring medical problems.

○ **NONE**

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

List any kind of surgery you have had.

○ **NONE**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any pertinent medical problems in your family and identify who (i.e. Mother, Father, Brother, Sister).
Mark NONE if you have no family medical problems.

○ **NONE**

1. _____ 3. _____
FAMILY MEMBER / CONDITION FAMILY MEMBER / CONDITION

2. _____ 4. _____
FAMILY MEMBER / CONDITION FAMILY MEMBER / CONDITION

Do you smoke or use any tobacco products? __Never __used to: smoke cigarettes, cigars, chew tobacco: Quantity per day ___week___ month year!

Do you use recreational drugs? __Never __I used to: I have used IV drugs!Current Use: What type? _____. How often? _____

Do you drink alcohol? __Never __I used to __ I am in recovery __I drink socially __regularly __Quantity per day / week / month / year

PHARMACY INFORMATION

We may be able to send your prescription directly to your pharmacy. Please list the pharmacy where you want your prescription sent.

PHARMACY NAME | **PHARMACY LOCATION**

The following individuals are authorized to speak to FIRST MED regarding my health information.

_____ _____ _____
Name/Relationship Name/Relationship Name/Relationship

My signature below acknowledges that I have been given a chance to review a copy of the FIRST MED Urgent Care Notice of Privacy Practices.

PATIENT SIGNATURE _____ *RELATIONSHIP IF OTHER THAN PATIENT* _____