East Beach URGENT CARE

TEMP:_____ RR:_____ **ROOM:**_____

HR:_____ O2:_____ HT:_____

BP:_____ WT:_____ PAIN:_____

New Patient History Form

Name:_____Age: _____Date of Birth: _____

Reason for visit today: _____ _____

Are you allergic to any medications? No or yes list (and reaction): _____

List all medications you are currently taking including non-prescriptions/over the counter:

Medication/Strength	Dose	Frequency

Medical Problems:

High Blood Pressure Diabetes Liver Disease Kidney/Bladder Problems Depression/Anxiety Arthritis Asthma

Thyroid Disease HIV/AIDS Drug or Alcohol Dependency Cancer (specify)_____ Other (specify) _____

Previous Surgeries: Approx Date

Last Menstrual Period: _____ Pregnant: Yes/No (weeks:_____) Breastfeeding: Yes/No

Smoke? _____ Packs per day _____ year started smoking _____

Drink alcohol? Never less than 1/week 1-3 week Daily

Recreational Drug Use: yes no Describe: _____

Family Medical History (conditions that began in family member before age 65)

Mom_____ Dad_____

Sibling_____ Grandparents_____