Lincoln Urgent Care

MEDICAL QUESTIONNAIRE

Patients Name: ____ **Date:** _________________________________

Reason for today's Visit: ____

Did your symptoms begin within the last 24 hours _____ Yes _____ No

Have you been treated for these symptoms previously _____ Yes _____No

Is this visit due to an Accident/Injury: ___ Yes __ No Type of Accident/Injury: ___Work ____ Auto ___ Other

Your Pharmacy Name: _______________________________ **Pharmacy Phone #:** (____) ______ -__________

Social History: Smoker _____ Yes _____No Packs per day: __________

Alcohol _____ Yes _____No If yes how often do you drink: _____ Every Day ____ Socially

History of/or current recreational drug use? _____ Yes _____ No

Are you allergic to any medications: ______ Yes ________ No

(If yes please list the Medications) __________________ _______________ ___________________

__________________ _______________ ___________________

Are you allergic to any of the following (please check off if you are): ________ Latex _______ Eggs

Please List Prior Surgeries: __________________________ _______________________ ____________________

__________________________ _______________________ ____________________

Please List All Medications/Vitamins/Supplements: _________________________ _______________________

_________________________ _______________________ _____________________

_________________________ _______________________ _____________________

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MEDICAL HISTORY

Patients Medical History: Please circle all that apply.

Anemia	**Arthritis**	**Asthma**	**Atrial Fibrillation**
Blood Clots/DVT	**Cancer** **Type: ___________**	**Chronic Bronchitis**	**COPD**
Crohn's Disease	**Depression/Anxiety**	**Diverticulitis**	**Diabetes:** **Type 1 or 2**
Emphysema	**Gout**	**Heart Attack**	**Hepatitis:** **A, B, C**
High Blood Pressure	**High Cholesterol**	**History of Fractures**	
HIV or AIDS	**Irritable Bowel Syndrome**		**Kidney Disease:** **Type: _________**
Migraines/Headaches	**Multiple Sclerosis**	**Osteoporosis**	**Parkinson's**
Rheumatoid Arthritis	**Stroke**	**Thyroid Disease**	**Other: ______________**

Patients Family History: Please check all that apply.

Cancer: Mother _____ Father ______ Type _____________	**Dementia**: Mother _____ Father ______	**Diabetes**: Mother___ Father ____ Type _________	**Gout**: Mother _____ Father ______
High Blood Pressure: Mother ______ Father _______	**Heart Disease:** Mother ______ Father _______	**Kidney Disease:** Mother _____ Father ______	**Stroke/Blood Clots:** Mother ____ Father _____

PATIENT SIGNATURE: ____ **Date**: _____/ _____/ _____