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

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

Alcohol _____ Yes _____No If yes how often do you drink: ____ daily ____weekly ____ socially

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

Please list any *medication* allergies: _____ _____ _____

Are you allergic to any of the following: _____ Latex _____ Eggs

Please List All Medications/Vitamins/Supplements: _____ _____

_____ _____ _____

_____ _____ _____ _____

X PATIENT SIGNATURE: _____ **Date**: _____/ _____/ _____

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MEDICAL HISTORY

Patients Medical History: Please circle all that apply.

Anemia	Arthritis	Asthma	Atrial Fibrillation
Blood Clots-DVT	Cancer (type)	COPD	Concussion
Crohn's disease	Depression/Anxiety	Diverticulitis	Diabetes: type I or II
Emphysema	Gout	Heart Disease	Hepatitis: A B or C
High blood pressure	High Cholesterol	HIV or AIDS	Irritable Bowel syndrome
Kidney disease	Multiple sclerosis	Osteoporosis	Parkinson's
Rheumatoid Arthritis	Stroke	Thyroid disease	Other

Please List Major Surgeries: _____

_____

_____

X PATIENT SIGNATURE: _____ **Date**: _____/ _____/ _____