i-Care URGENT CARE

Medical History

Full name: _____ Date of birth: _____ Today's date: _____

Primary doctor: _____

Doctor who requested today's visit: _____

List current/previous doctors and their specialties: _____

_____

ALLERGIES & REACTIONS:

_____

_____

_____

_____

MEDICATIONS: (list dosage and how you take them, including non prescriptions, herbs & birth control)

_____

_____

_____

_____

PAST MEDICAL ILLNESSES: (Please check if you have had the following):

- ☐ Alcohol/Drug addiction
- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorder
- ☐ Blood clot
- ☐ Blood transfusion
- ☐ Cancer
  - ☐ Breast ☐ Ovarian
  - ☐ Colon ☐ Uterine
  - ☐ Other:
- ☐ Crohn's disease
- ☐ COPD/Emphysema
- ☐ Depression
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Gout
- ☐ Hay fever
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Hepatitis B/C
- ☐ High cholesterol
- ☐ HIV
- ☐ Hypertension
- ☐ Kidney disease
- ☐ Kidney stone
- ☐ Liver disease
- ☐ Seizure
- ☐ Sexually transmitted disease (type): _____
- ☐ Sickle cell disease
- ☐ Sleep apnea
- ☐ Stomach ulcer
- ☐ Stroke
- ☐ Thyroid
- ☐ Tuberculosis
- ☐ (Positive) TB test
- ☐ Ulcerative colitis
- ☐ Other: _____

OPERATIONS	DATES	HOSPITALIZATIONS	DATES

FAMILY HEALTH HISTORY: ☐ Adopted

Family Member	Major Medical Problems	If Deceased, Causes	Age at Death
Maternal Grandmother			
Paternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Mother			
Father			
Brother /Sisters			
Sons/Daughters			

SOCIAL HISTORY:

Occupation: Marital Status: Children: ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No How often? How many drinks?

Do you smoke? ☐Yes ☐No Packs per day: ☐.25 pack ☐1.5 packs How many years?

Are you a former smoker? ☐Yes ☐No ☐.50 pack ☐ 2.0 packs Year quit?

Do you chew tobacco? ☐Yes ☐No ☐1.0 pack ☐ Other:

Do you use recreational/illegal drugs? ☐Yes ☐No

Have you worked with asbestos or other hazardous material? ☐Yes ☐No

Do you have a living will? ☐Yes ☐No Health care proxy? ☐Yes ☐No If so, who?
Advanced Directive for Healthcare

HEALTH MAINTANCE:

Last menstrual period:_____ Last pap smear: _____ Last mammogram:_____.

Last colonoscopy:_____Last prostate cancer screening:_____ Last bone density scan:_____.

Immunizations: ☐Pneumovax:_____☐Flu:_____☐Tetanus:_____☐Hep A:_____☐Hep B:_____.

REVIEW OF YOUR SYMPTOMS (Please check if you have recently had the following symptoms):

☐Weight gain	☐Persistent cough	☐Blood in stool	☐Headaches
☐Weight loss	☐Chest discomfort	☐Difficulty urinating	☐Memory loss
☐Night sweats	☐Palpitations	☐Trouble holding urine	☐Numbness/Tingling
☐Weakness	☐Fainting	☐Frequency of urination	☐Tremor
☐Fatigue	☐Change in exercise intolerance	☐Penis discharge	☐Mood swings
☐Insomnia	☐Difficulty swallowing	☐Vaginal discharge/bleeding	☐Anxiety
☐Change in hearing	☐Indigestion/ heartburn	☐Nipple discharge	☐Depression
☐Change in vision	☐Nausea	☐Breast pain	☐Skin rash
☐Runny nose	☐Vomiting	☐Breast lump	☐Back pain
☐Nose bleed	☐Constipation	☐Pain with intercourse	☐Leg pain
☐Fever	☐Diarrhea	☐Feeling too hot	☐Leg swelling
☐Blood in sputum	☐Change in bowel habits	☐Feeling too cold	☐Other: _____.
☐Shortness of breath	☐Blood in vomit	☐Dizziness	

Please list all you reason(s) for visiting in order of priority:

1. _____

_____

_____

2. _____

_____

_____

3. _____

_____

_____

_____ _____ _____ _____

Patient/Designee signature Patient name **(PRINT)** Date Time

_____ _____

Relationship to patient Reason patient is unable to sign