Great Lakes Urgent Care Group

Name: _____ DOB: _____

(Please Print)

Medical History: Have you ever had? Check "Y" for a yes response, "N" for a no response. Please answer all questions.

	Y	N		Y	N		Y	N
Measles			Pneumonia			Angina		
Chicken Pox			Scarlet Fever			High or Low Blood Pressure		
Bone / Joint Disease			Migraine Headache			Asthma		
Cancer			Venereal Diseases			Stroke		
Tuberculosis			Diabetes			Hernia		
Stomach Ulcers			Nervous Breakdown			Kidney Problems		
Hives / Rashes			Thyroid Problems			Back Pain		
Heart Trouble			Liver Trouble			Alcohol / Drug Problems		

Hospital Admissions: Include year you were admitted to hospital and reason.

Year	Illness or Operation	Year	Illness or Operation

Medications: List all medications that you are now taking. Include over the counter medications and herbal medications.

Name of Drug	Strength	How Often	Name of Drug	Strength	How Often
			Drug Allergies:	Other Allergies:	

Immunization: Please indicate the year of the last dose of each vaccine.

Tetanus / Diphtheria		Flu		Pertussis	

Menstrual History (Women Only)

Date of last period	Number of pregnancies
Age of first period	Number of lives births

Social History: Please complete all questions.

Smoking History: ☐ Do not smoke ☐ Quit Smoking, when? How long have you smoked? How many packs a day?

Alcohol use: Yes/No If yes, how many drinks per week?

Family History: If any blood relative has suffered from the following – please indicate which relative.

Tuberculosis		Stroke		Migraines		Heart Disease	
Epilepsy		Diabetes		Cancer		High Blood Pressure	
Arthritis		Kidney Disease		Mental Illness			

Systems Review: Do you currently have? Check "Y" for a yes response, "N" for a no response. Please answer all questions.

	Y	N		Y	N		Y	N
Fatigue			High Blood Pressure			Rash		
Weakness			Chest Pain			Eczema / Psoriasis		
Insomnia			Irregular Heartbeat			Hives		
Weight Loss								
Weight Gain			Joint Pain / Swelling			Loss of Appetite		
			Back Pain			Trouble Swallowing		
Headaches			Varicose Veins			Nausea / Vomiting		
Blurry Vision			Swollen Ankles			Abdominal Pain		
Double Vision						Change in Bowel Movement		
Eye Pain			Fainting Spells			Painful / Bloody Stool		
Hearing Loss			Dizziness					
Ringing in Ears			Seizures			**Females**		
Earaches			Tremors			Painful Sex		
Sore Throats			Numbness			Vaginal Discharge		
Hoarseness						Breast Soreness / Discharge		
Bleeding Gums			Depression			Breast lumps		
Swollen Gums			Nervousness			Painful Urination		
			Mental Illness					
Chronic Cough						**Males**		
Coughing up Blood			Anemia			Pain / Swelling of Testicles		
Shortness of Breath			Easy Bruising			Trouble Urinating		
			Cancer			Penile Sores or Discharge		

I HEREBY CERTIFY THAT: I have carefully read and completed the foregoing information, and that my answers and explanations are true to the best of my knowledge and belief.

Signature: _____ Date: _____/_____/_____

Reviewed by Physician	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial
	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial	Date/Initial