PALMERS URGENT CARE AND DIAGNOSTICS, INC.

PATIENT MEDICAL HISTORY

NAME : _____ DOB : _____

MEDICATIONS: List all prescription & over the counter drugs , Their strength (mg), and # of tablets /day you are currently taking					
DRUG	**STRENGTH (mg, mcg)**	**Number taking Per Day**	**DRUG**	**STRENGTH (mg, mcg)**	**Number taking Per Day**

ALLERGIES: LIST ALLKNOWN ALLERGIES, INCLUDING MEDICATIONS AND REACTIONS.	
ALLERGY :	**REACTION :**

MEDICAL HISTORY: INDICATE IF YOU HAVE NAY OF THE FOLLOWING.

YES	**NO**		**YES**	**NO**		**YES**	**NO**	
		HIGH BLOOD PRESSURE			**YELLOW JAUNDICE**			**HEPATITIS**
		DIABETES			**GALLSTONES**			**GLAUCOMA**
		PEPTIC ULCERS			**KIDNEY STONES**			**LUNGPROBLEMS/ASTHMA**
		HEART ATTACK			**DIVERTICULOSIS**			**STROKE**
		HISTORY OF HEART MURMUR			**THYROID PROBLEM**	**LIST ACCIDENTS & BROKEN BONES :**		
		CANCER (TYPE)			**STD INFECTION**			

FEMALES ONLY : NUMBER OF PREGNANCIES : ***NUMBER OF LIVE BIRTHS :*** ***NUMBER OF MISCARRIGES :***

BIRTH CONTROL METHOD : ***HAVE YOU EXPIERENCED MENOPAUSE*** ☐ ***YES*** ☐ ***NO***

SURGICAL HISTORY: List all operations and hospitalizations and any complications.

YEAR	**TYPE OF SURGERY / HOSPITALIZATION**	**COMPLICATIONS**

FAMILY HISTORY: Indicate if your family has a history of these conditions by checking "**F**" for Father "**M** " for Mother "**S** for Sibling (may check more than one)

HEART DISEASE	**F**	**M**	**S**	**KIDNEY PROBLEMS**	**F**	**M**	**S**	**DIABETES**	**F**	**M**	**S**	**SEIZURE DISORDER**			**F**	**M**	**S**
CANCER TYPE	**F**	**M**	**S**	**DEPRESSION**	**F**	**M**	**S**	**SCHIZOPHRENIA**	**F**	**M**	**S**	**EARLY SENILITY**			**F**	**M**	**S**
ALCOHOLISM	**F**	**M**	**S**	**STROKE**	**F**	**M**	**S**	**OBESITY**	**F**	**M**	**S**						
MANIC DEPRESSIVE DISORDER	**F**	**M**	**S**	**HIGH BLOOD PRESSURE**	**F**	**M**	**S**	**OTHER SPECIFY**					**F**	**M**	**S**		

SOCIAL HISTORY: MARTIAL STATUS ___ SINGLE ___ MARRIED ___ SEPARATED ___ DIVORCED ___ WIDOWED

YES	**NO**	
		Do you smoke? If YES, how many packs per day: _____ If NO , have you ever smoked in the past?
		Do you drink alcohol? If YES, what kind and how much: If No, have you ever drunk alcohol in the past?
		Do you use street drugs?
		Have you ever had a blood transfusion? If yes when :
		Do you have any tattoos?
		Do you have a history of IV Drug use?