COMMUNITY
URGENT CARE OF FULTONDALE

Last Name:	First Name:	DOB:	☐ F ☐ M ☐ ________
Marital Status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			Occupation:
Previous or Referring Doctor:			Date of last physical exam:

Medications: Please bring all prescription medications you are currently taking

Name	Dose and Directions	Reason

Allergies and Reactions: ______________________________

____

Do you currently have, or have ever had, any of the following illnesses or conditions?

☐ Abnormal Pap	☐ Gallbladder Disease	☐ Osteoporosis
☐ Alcohol/Drug Problem	☐ Glaucoma	☐ Other Injuries
☐ Anemia	☐ Gout	☐ Peripheral Artery Disease
☐ Anxiety/Depression	☐ Hay Fever	☐ Pneumonia
☐ Arthritis	☐ Head Injury	☐ Positive TB Test
☐ Asthma	☐ Heart Attack	☐ Prostate Problem
☐ Atrial Fibrillation	☐ Heart Disease	☐ Psychiatric-Depression
☐ Blood Clots	☐ Heart murmur	☐ Psychiatric-Other
☐ Cancer	☐ Hepatitis/Liver Disease	☐ Rheumatic Fever
☐ Chicken Pox	☐ Hernia	☐ Seizures
☐ Chronic Lung Disease	☐ High Blood Pressure	☐ Sexually Transmitted Disease
☐ Colon/Bowel Disease	☐ High Cholesterol	☐ Sleep Apnea
☐ Dementia	☐ Infection of the uterus	☐ Stroke
☐ Diabetes Type I or II	☐ Kidney Disease	☐ Thyroid Disease
☐ Diverticulitis	☐ Migraines	☐ Tuberculosis
☐ Emphysema	☐ Neuropathy	☐ Ulcer

Surgical and Hospitalization History (include dates)

Family History *(Use back of page if needed)*			**Age**	**Medical conditions** Indicate **Healthy** -or- diabetes, high blood pressure, cholesterol, heart disease, stroke, cancer (type)
Mother		□ Living □ Deceased		
Father		□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Sibling	□ F □ M	□ Living □ Deceased		
Grandmother Mother's Side		□ Living □ Deceased		
Grandfather Mother's Side		□ Living □ Deceased		
Grandmother Father's Side		□ Living □ Deceased		
Grandfather Father's Side		□ Living □ Deceased		
Children	□ F □ M	□ Living □ Deceased		
Children	□ F □ M	□ Living □ Deceased		
Extended Family Members			□ Cancer □ Heart attacks □ Stroke □ Diabetes	

Patient History				
Smoking	**Cigarette Use:**	☐ Never ☐ Former Smoker ☐ Current Smoker	Date quit or age:	
	Other tobacco use:	☐ Pipe	☐ Cigars	☐ Chewing Tobacco
	Other:	☐ e-Cigarettes	☐ Marijuana	
Alcohol	**Do you drink alcohol?**	☐ Yes ☐ No	☐ 0-1 times/month ☐ 2-4 times/month	☐ Every week
	Each week, how many:_____ Servings of beer? _____ Glasses of wine?_____ Shots/mixed drinks?_____			
	When did you last have more than 4 drinks in one day? ________________			
	Do you feel you should cut down on your drinking?		☐ Yes	☐ No
	Do people annoy you by nagging about your drinking?		☐ Yes	☐ No
	Have you ever felt guilty about drinking?		☐ Yes	☐ No
	Have you ever had a morning drink to steady your nerves?		☐ Yes	☐ No
Drugs	Have you used recreational or street drugs within the last two years?		☐ Yes	☐ No
	Have you ever used recreational drugs with a needle?		☐ Yes	☐ No
Sexual Health	☐ Sexually active ☐ Not currently sexually active ☐ Never sexually active			
	Sexual Partners: ☐ Men ☐ Women		# of Partners in last year:	
	History of Sexually Transmitted infections? If yes, type/dates:			
	Current contraception method:		Previous methods:	
	Women: # of children:______ # of pregnancies:______ # of miscarriages:______ # of abortions:______ Date of last menstrual period:			

Personal Safety			
	Do you wear a seatbelt?	☐ Yes	☐ No
	Have you fallen in the last year?	☐ Yes	☐ No
	If yes, how many times?_____ Any injuries?_____		
	Do you feel unsteady when standing or walking?	☐ Yes	☐ No
	Do you worry about falling?	☐ Yes	☐ No
	Does your house have a working smoke detector?	☐ Yes	☐ No
	Does a partner, or anyone at home, hurt, hit, or threaten you, or take advantage of you financially?	☐ Yes	☐ No

Patient Health

Over the last two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things
☐ Not at all ☐ Several Days ☐ More than Half of the Days ☐ Nearly Every Day

Feeling down, depressed, or hopeless
☐ Not at all ☐ Several Days ☐ More than Half of the Days ☐ Nearly Every Day

Exercise

- ☐ Sedentary (No exercise)
- ☐ Mild Exercise (i.e., climb stairs, walk three blocks, golf)
- ☐ Occasional vigorous exercise (i.e., work or recreation 1-3x week for 30 minutes)
- ☐ Regular vigorous exercise (i.e., work or recreation > 3x/week for 30 minutes)

Immunizations	**Date**	**Immunization**	**Date**
☐ Flu Vaccine		☐ TD (Tetanus Shot)	
☐ TDAP (Whooping Cough/Tetanus)		☐ Zostavax (Shingles) ☐ Shingrix (Shingles)	
☐ Pneumococcal PCV13		☐ HPV	
☐ Pneumococcal PPV23		☐ Meningococcal ACWY	
☐ Hepatitis A		☐ Meningococcal B	
☐ Hepatitis B		☐ Other:	

Please list the names of the physicians and specialists you have seen:

Previous Primary Care		Gynecologist	
Gastroenterologist (GI)		Urologist	
Cardiologist		Eye doctor	
Other		Other	

Preventative Screenings: To avoid duplication and to provide you with the best care possible, we would like the information on the following items and to obtain a copy of your most recent reports. **Either bring a us a copy** or **let us know from where we can request a copy**. (Not all ages and genders will need to provide the information listed below.)

Item	**Date last performed**	**Result (if applicable)**	**Comments**
Aortic Aneurysm Screen			
Bone Density Test			
Cholesterol Test			
Colonoscopy			
Dental Exam			
Eye Exam			
Hepatitis C Test			
HIV Test			
HPV Test			
Mammogram			
Pap Smear			
Prostate Exam			
Stool Test for Blood			

Additional Comments: (use back of page if needed)

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