NEWPORT Urgent CARE INC. OCCUPATIONAL MEDICINE

BREA Urgent CARE INC. OCCUPATIONAL MEDICINE

Patient Health History

Name: _____ Date _____
Date of Birth: _____
Reason for Today's Visit: _____

Previous Primary Care Physician: _____
Phone Number: _____

Current Specialists:
1) Name: _____ 2) Name: _____
Specialty: _____ Specialty: _____
Phone: _____ Phone: _____

Note: If you are currently seeing more specialists than the space above allows, please list the additional specialists on the back of this form.

Allergies: Any known drug allergies? ○No ○Yes
Please list all allergies including food, medications and environmental and reaction.

_____

Do you currently take any medications on a regular basis? ○No ○Yes
If yes, please list any medications that you currently take on a regular basis (include non-prescriptions).

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Note: If you are currently taking more medications than the space above allows, please list the additional medications on the back of this form.

MEDICAL HISTORY

Illness & Conditions – Do you have or have you ever had any of the following:

	YEAR
☐ Alcoholism	
☐ Anxiety	
☐ Anemia	
☐ Arthritis	
☐ Asthma	
☐ Bleeding Problems	
☐ Birth Defects	
☐ Cancer (Type: _____)	
☐ Colitis	
☐ Concussion	
☐ Depression/Nervous Breakdown	
☐ Diabetes	
☐ Emphysema	
☐ GERD/Heartburn/Reflux	
☐ Gout	
☐ Heart Attack/Heart Disease	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Kidney Disease	
☐ Lupus	

Have you had any past medical problems?
○ No ○ Yes If yes, list below:

Have you had any previous surgeries or hospitalizations?
○ No ○ Yes If yes, list details and date below:

Childhood Diseases

	YEAR
☐ Chicken Pox	
☐ Measles	
☐ Mumps	
☐ Polio	
☐ Other: _____	

- ☐ Liver Disease/Hepatitis _____
- ☐ Migraine Headache _____
- ☐ Mitral Valve Prolapse/Murmur _____
- ☐ Osteoporosis _____
- ☐ Prostate Enlargement (BPH) _____
- ☐ Rheumatoid Arthritis _____
- ☐ Seizure Disorder _____
- ☐ Sexually Transmitted Disease _____
- ☐ Skin Problems _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____
- ☐ Tuberculosis _____
- ☐ Other: _____ _____

Gynecological History (women only)

Last Menstrual Period _____
How many pregnancies have you had? _____
How many children do you have? _____
Have you ever had an abnormal pap smear? _____
Have you had a hysterectomy? _____
Have your ovaries been removed? _____

Sexual History

Do you have sex with ○Men ○Women ○Both
Have you had an HIV Test? ○Yes ○No
Do you use condoms for sexual intercourse? ○Yes ○No

FAMILY HISTORY

Do you have any family history of serious illness? ○No ○Yes
If yes, list below:

	MOTHER	FATHER	GRANDPARENT
Alcoholism	○	○	○
Asthma	○	○	○
Bleeding Problems	○	○	○
Cancer (Type:_____)	○	○	○
Diabetes	○	○	○
Emphysema	○	○	○
Glaucoma	○	○	○
Heart Attack	○	○	○
Heart Disease	○	○	○
High Blood Pressure	○	○	○
Mental Illness/Suicide	○	○	○
Osteoporosis	○	○	○
Seizures	○	○	○
Stroke	○	○	○
Thyroid	○	○	○

	LIVING AGE	DECEASED AGE AT DEATH & CAUSE
Father		
Mother		
Brother		
Sister		
Son		
Daughter		

HEALTH MAINTENANCE

When did you last have any of the following:

_____Diabetes Check
_____Prostate Check
_____Colonoscopy
_____Mammogram
_____Pap Smear
_____Cholesterol Check
_____Cardiac Stress Test
_____Bone Density

List year of Last Vaccinations:

_____Tetanus (TD)
_____Influenza (Flu)
_____Pneumonia
_____Shingles (VZV)
_____Hepatitis A
_____Hepatitis B
_____HPV
_____TB Skin Test

SOCIAL HISTORY

Marital Status: ○Single ○Married ○Partnered ○Co-habiting ○Separated ○Divorced ○Widowed

Do you have children/dependents at home? ○Yes ○No How many? _____
Are you employed? ○Yes ○No Occupation: _____
What is your highest level of education? ○High School ○College ○Graduate School
Do you or have you ever smoked or chewed tobacco? ○Yes ○No When? _____ Quit Date: _____
○Packs/○Cans/○Bags per day_____/years _____
Do you or have you ever used recreational drugs? ○Yes ○No Type: _____ How Often? _____
Do you drink alcohol? ○Yes ○No Type: _____ How Often? _____
How much per day? _____ / _____ years
Have you ever been exposed to toxic substances? ○Yes ○No Type: _____ What Kind? _____
Do you drink caffeine? ○Yes ○No Type: _____ How Often? _____
Do you exercise? ○Yes ○No Type: _____ How Often? _____
Do you wear a seat belt? ○Yes ○No
Do you use car seats for your children if under 60 lbs.? ○Yes ○No
Do you have a living will or advance directives? ○Yes ○No