CENTENARY FAMILY & URGENT CARE

HEALTH QUESTIONNAIRE

Name: _____ **Birth Date:** ____/_____/_____ **Date:** ____/_____/_____
Last First M

Gender: □ Male □ Female, if yes: □ Pregnant? □ Breastfeeding? **How many Kids** _____ **Last Period:**_____

Reason for visit today? _____

List all your current medications, including non-prescription drugs: □ none _____

_____

Medication Allergies: □ No known allergies _____

PAST MEDICAL HISTORY (Check all that apply & Specify) □ NONE APPLY

□ Allergies _____ □ Diabetes (type)_____ □ High Cholesterol_____
□ Anxiety_____ □ Emphysema/COPD_____ □ Kidney Disease_____
□ Asthma_____ □ Epilepsy/Seizure Disorder _____ □ Liver Disease_____
□ Arthritis_____ □ Headaches_____ □ Stroke_____
□ Cancer _____ □ Heart Disease _____ □ Thyroid Disease_____
□ Depression_____ □ High Blood Pressure _____ □ Other (specify)_____

HOSPITALIZATION & SURGERY (Check all that apply, specify and write in date below) □ NONE APPLY

□ Appendix _____ □ Heart Surgery _____ □ Tubal Ligation _____
□ Adenoids _____ □ Hernia _____ □ Vasectomy _____
□ Back _____ □ Hysterectomy _____ □ C-Section _____
□ Breast _____ □ Tonsillectomy _____ □ Other (specify)_____

FAMILY HISTORY (Check all that apply & specify) □ NONE APPLY

□ Asthma _____ □ Diabetes_____ □ Stroke_____
□ Cancer (specify) _____ □ Heart Disease _____ □ Thyroid Disease_____
□ Dementia/Alzheimer's _____ □ High Blood Pressure _____ □ C-Section _____
□ Depression _____ □ High Cholesterol _____ □ Other _____

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Divorced □ Widowed
Do you smoke? □ No □ Yes _____ packs/day
Do you drink alcoholic beverages? □ No □ Yes

for the MINOR patient:
Child lives with: □ Parents □ Grandparents
□ Other _____

Do you use any recreational drugs or medications not prescribed to you? □ No □ Yes, _____

***I have read the above information and consent that it is correct to the best of my knowledge. I authorize Centenary Family & Urgent Care and its health care providers to render necessary treatment for my condition.**

_____ _____
Signature of Patient/Guardian **Date**

This form has been reviewed by the treating physician:

_____ _____
Signature of Physician/ Provider **Date**