Urgent Care Center
MEDSTOP
Madonna Plaza SLO

PAST MEDICAL HISTORY QUESTIONNAIRE

PRINT YOUR FULL NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ SEX AT BIRTH: FEMALE / MALE GENDER IDENTITY: _____

LIST ALL ALLERGIES: (PLEASE INCLUDE PRESCRIPTION, OVER-THE-COUNTER MEDICATION & FOOD ALLERGIES)

□ NO KNOWN MEDICATION ALLERGIES □ NO KNOWN FOOD ALLERGIES

MEDICATION: _____ REACTION: _____
MEDICATION: _____ REACTION: _____
MEDICATION: _____ REACTION: _____
MEDICATION: _____ REACTION: _____
OTHER: _____ REACTION: _____
OTHER: _____ REACTION: _____

LIST ALL OF YOUR CURRENT MEDICATIONS: (PLEASE INCLUDE ALL "OVER THE COUNTER" MEDICATIONS & SUPPLEMENTS)

□ NO CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	REASON

NAME OF PHARMACY YOU USE: _____

LOCATION OF PHARMACY YOU USE: _____

PAST MEDICAL HISTORY: (PLEASE CIRCLE YOUR ANSWERS)

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

			ADDITIONAL INFORMATION
HIGH BLOOD PRESSURE	NO	YES	_____
HEART DISEASE	NO	YES	_____
DIABETES	NO	YES	_____
CANCER / TUMOR	NO	YES	_____
ULCERS / GERD	NO	YES	_____
ASTHMA / COPD	NO	YES	_____
BLOOD CLOTS / DVT	NO	YES	_____
CHRONIC PAIN	NO	YES	_____
SEIZURES	NO	YES	_____
HEPATITIS	NO	YES	_____
KIDNEY DISEASE	NO	YES	_____
RECURRENT INFECTIONS	NO	YES	_____
ANY SIGNIFICANT INJURIES?	NO	YES	_____

PLEASE COMPLETE BACK SIDE NOW

PAST MEDICAL HISTORY CONTINUED

LIST OTHER SIGNIFICANT MEDICAL PROBLEMS YOU HAVE HAD: _____

_____

_____

_____

_____

LIST ANY SURGERY / OPERATIONS / HOSPITALIZATIONS YOU HAVE HAD, INCLUDING THE DATES: _____

_____

_____

_____

_____

_____

OTHER PERTINENT MEDICAL HISTORY: _____

_____

_____

SOCIAL HISTORY: **CIRCLE ONE**

TOBACCO USE:	□ SMOKE	□ CHEW	□ VAPE	AMOUNT _____ PER DAY / WEEK
ALCOHOL USE:	TYPE: _____			AMOUNT _____ PER DAY / WEEK
ILLICIT DRUG USE:	TYPE: _____			AMOUNT _____ PER DAY / WEEK

MEDICALLY RELATED FAMILY HISTORY:

HEART DISEASE	NO	YES	□ FATHER	□ MOTHER	□ SIBLING	□ GRANDPARENTS
DIABETES	NO	YES	□ FATHER	□ MOTHER	□ SIBLING	□ GRANDPARENTS
CANCER / TUMOR	NO	YES	□ FATHER	□ MOTHER	□ SIBLING	□ GRANDPARENTS
HEREDITARY DISEASE	NO	YES	□ FATHER	□ MOTHER	□ SIBLING	□ GRANDPARENTS
OTHER DISEASES	NO	YES	□ FATHER	□ MOTHER	□ SIBLING	□ GRANDPARENTS
EARLY DEATH <40YRS OLD	NO	YES	□ FATHER	□ MOTHER	□ SIBLING	□ GRANDPARENTS

PROVIDER REVIEW: _____