CELL #: _____

We require all patients to update their Medical History Form at least once per year or as their medical history changes.

EDMOND URGENT CARE

NAME: _____ DOB: ___/___/___ Today's Date: ___/___/___

What symptoms are you having today_____?
If female, is there any chance that you might be pregnant? YES, or NO Date of LMP___/___/___ or N/A
Has your medication list been updated since your last visit? YES, or NO If so, please list below:
_____

_____
Do you have any ALLERGIES to drug, latex, food, insects etc.? YES, or NO, if so, please list below:
_____
_____

Since your last visit, have you had any Surgeries; general cardiovascular, respiratory, musculoskeletal, hematologic, gastrointestinal, genitourinary, neurological, psychiatric, skin, breast, head, eye, ear or nose problems? YES, or NO, If so, please list below:
_____
_____
_____

Pharmacy Preference (address/location). _____
_____
_____

****

FOR OFFICE USE ONLY

****

TIME **BP** / **Pulse** **Sat** %

Weight **Height** **Resp** **Temp**

MED	DOSE	ROUTE	SITE	TIME
1.				
2.				
3.				
4.				

ADDITIONAL NOTES: _____
_____
_____
_____

RADIOLOGY
_____

MONO
POS **NEG**

COVID-19
POS
NEG

URINE DIPSTICK
Glucose: _____
Ketones: _____
S.G._____
Blood: _____
pH: _____
Protein: _____
Nitrates: _____
Leukocytes: _____

Strep A
POS **NEG**

Influenza
POS **NEG**
A **or** **B**

HEMOCCULT
POS **NEG**

RSV
POS **NEG**

HCG
URINE OR SERUM
POS **NEG**