Urgent Care Center
MEDSTOP
Madonna Plaza SLO

PAST MEDICAL HISTORY QUESTIONNAIRE

PRINT YOUR FULL NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: Female / Male

LIST ALL ALLERGIES TO MEDICATIONS: _____

LIST ALL OF YOUR CURRENT MEDICATIONS: (DO NOT WORRY ABOUT SPELLING)
PLEASE INCLUDE ALL "OVER THE COUNTER" MEDICATIONS AND SUPPLEMENTS:

_____

_____

Name of the pharmacy/location that 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	_____
RECURRENT INFECTIONS	NO	YES	_____

LIST OTHER SIGNIFICANT MEDICAL PROBLEMS/ INJURIES YOU HAVE HAD: _____

_____

LIST ANY SURGERY / OPERATIONS / HOSPITALIZATIONS YOU HAVE HAD: _____

_____

MEDICALLY RELATED FAMILY HISTORY: (PLEASE CIRCLE YOUR ANSWERS)

			ADDITIONAL INFORMATION
HEART DISEASE	NO	YES	_____
DIABETES	NO	YES	_____
CANCER / TUMOR	NO	YES	_____
HEREDITARY DISEASE	NO	YES	_____
OTHER DISEASES	NO	YES	_____
EARLY DEATH <40YRS OLD	NO	YES	_____

PROVIDER INITIAL: _____