

PATIENT HISTORY QUESTIONNAIRE

LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH	SEX M F	

List any allergies you have including medications, food or any other negative reaction.

NKDA (no known drug allergies)

Allergies: _____

List any medications you are currently taking, including over the counter medication. Please List medication strength and how often you take the medication. NONE

1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

List all long term or recurring medical problems. NONE

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

List any pertinent medical problems in your family and identify who (i.e. Mother, Father, Brother, Sister). Mark NONE if you have no family medical problems. NONE

1. _____	3. _____
2. _____	4. _____

List any kind of surgery you have had. NONE

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Do you smoke or use any tobacco products?

Never I used to I smoke cigarettes I smoke cigars I use chewing tobacco

Do you drink alcohol?

Never I used to I am in recovery I drink socially I drink regularly

Do you use recreational drugs?

Never I used to Sometimes Frequently I have used IV drugs

The following individuals are authorized to speak to FIRST MED regarding my health information.

Name/Relationship	Name/Relationship	Name/Relationship
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My signature below acknowledges that I have been given a chance to review a copy of the FIRST MED Urgent Care Notice of Privacy Practices.

PATIENT SIGNATURE _____ RELATIONSHIP IF OTHER THAN PATIENT _____