SARASOTA MEMORIAL URGENT CARE CENTER MEDICAL QUESTIONNAIRE

LIST ALL ***MEDICATIONS & SUPPLEMENTS*:**

_____

_____

LIST ALL ***ALLERGIES and REACTIONS*** *YOU HAVE TO MEDICATIONS*:

_____

_____

SYMPTOMS FOR TODAY'S VISIT: (Please describe)

_____

_____

MEDICAL CONDITIONS TREATED NOW OR IN THE PAST YEARS: (Please check all that apply)

___Hypertension	___Asthma	___ Diabetes
___Heart Attack/Heart Failure	___Sinus/Allergies	___ Thyroid
___Angina	___Pneumonia	___ Headaches
___Heart Stents	___C.O.P.D/Emphysema	___ Depression/Anxiety
___Stroke	___Black Lung Disease	___ Seizures
___High Cholesterol	___End Stage Renal Disease	___Arthritis of_____
___Irregular Heart Rhythm	___Kidney Stones	___Fibromyalgia
___Bleeding Disorder	___Urinary Infections	___Cancer of_____
___Blood Clots	___ Prostate Cancer	___OTHER:_____
___Bowel/Digestive Problems	___ Prostate Enlargement	_____
___Stomach Ulcers/Reflux Disease	___ Dialysis Treatments	

PAST SURGICAL HISTORY: (Please check all that apply)

___Heart Bypass	___Back	___Leg Artery Bypass R / L
___Abdominal Aneurysm	___Carotid Artery	___Gallbladder
___Appendectomy	___Hysterectomy	___Joint Replacement of _____
___Breast R / L	___Tonsillectomy	___OTHER:_____
___Brain	___Prostate Surgery/Radiation	_____

FAMILY MEDICAL HISTORY: (Check) __Heart Disease __High Blood Pressure __Diabetes __Cancer
__Other:_____

SOCIAL HISTORY:
Do you feel safe at home? Y_____N_____
Tobacco Use: Yes Never Quit (When?) _____ If Yes, Packs Per Day?_____
Do You Drink Alcohol? Y____ N ____ How Much Per Day? _____

Health Maintenance: Pneumonia Shot / Date:_____ Shingles Shot/Date:_____
Tetanus Booster/Date:_____ Flu Shot / Date:_____

PATIENT FULL NAME: _____

PATIENT LABEL HERE