Tri-County Health and Wellness Urgent Care Center

Health History Questionnaire

All questions contained in the questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, MI)*:	☐ Male ☐ Female	**Age:**	**Date of birth:**

Marital status:
☐ Single ☐ Married ☐ Other ☐ Divorced ☐ Widowed

Occupation:

Referring Doctor — Name — Phone Number
Street Address — City — State — Zip Code

Primary Care Doctor — Name — Phone Number
Street Address — City — State — Zip Code

Referral Source: ☐ Doctor ☐ Friend ☐ Internet ☐ TV/Radio

Present Problem

Chief Complaint:

How long have you had this problem?

What caused the problem?

What makes your symptoms worse?

Do you have any weakness and if so where?

Do you have any numbness and if so where?

What other treatments have you had? ☐ Physical Therapy ☐ Injections

Is this a work related problem? ☐ Yes ☐ No Accident date:

Is there any lawsuit regarding the injury? ☐ Yes ☐ No

Past Medical History

Height:

Weight:

Please check each applicable diagnosis:

☐ Hypertension ☐ Heart disease
☐ Liver disease ☐ Diabetes ☐ If yes, insulin dependent?
☐ Kidney disease ☐ Cancer Type:
☐ Thyroid disease

Other medical problems:

Past surgeries & hospitalizations *(Please include year and hospital)*:

☐ Have you ever had a blood transfusion?

Medication & Allergy Review

List ALL medications or supplements:

Drug	Dosage	Drug	Dosage

List ALL drug or medical allergies :

Allergy	Reaction

Systems Review

Check applicable symptoms and add additional as needed:

Skin ☐Yes ☐No Ex: Rashes Lesions	**Eyes** ☐Yes ☐No Ex: Eye pain/burning Loss of vision Double vision	**Constitutional** ☐Yes ☐No Ex: Fever Weight gain/loss	**Chest/Heart** ☐Yes ☐No Ex: Chest pain Palpitations	**Neurological** ☐Yes ☐No Ex: Memory changes Difficulty walking Slurred speech
Genitourinary ☐Yes ☐No Ex: Urinary frequency Burning with urination Sexual function problems	**Throat** ☐Yes ☐No Ex: Sore throat	**Head/Neck** ☐Yes ☐No Ex: Neck pain Headaches	**Back** ☐Yes ☐No Ex: Low back pain	**Endocrine** ☐Yes ☐No Ex: Excessive thirst Cold/heat intolerance
Gastrointestinal ☐Yes ☐No Ex: Abdominal pain Nausea/vomiting Rectal bleeding	**Hematological** ☐Yes ☐No Ex: Easy brusing Easy bleeding Lymph node swelling	**Psychiatric** ☐Yes ☐No Ex: Depression Anxiety Psychosis	**Lungs** ☐Yes ☐No Ex: Cough Shortness of breath	**Ears/Nose** ☐Yes ☐No Ex: Hearing loss Ringing Nose bleeding

Mental Health:

Is stress a major problem for you? ☐Yes ☐No

Do you feel depressed? ☐Yes ☐No

Have you ever attempted suicide? ☐Yes ☐No

Do you have trouble sleeping? ☐Yes ☐No

Social History

Please check those applicable to you:

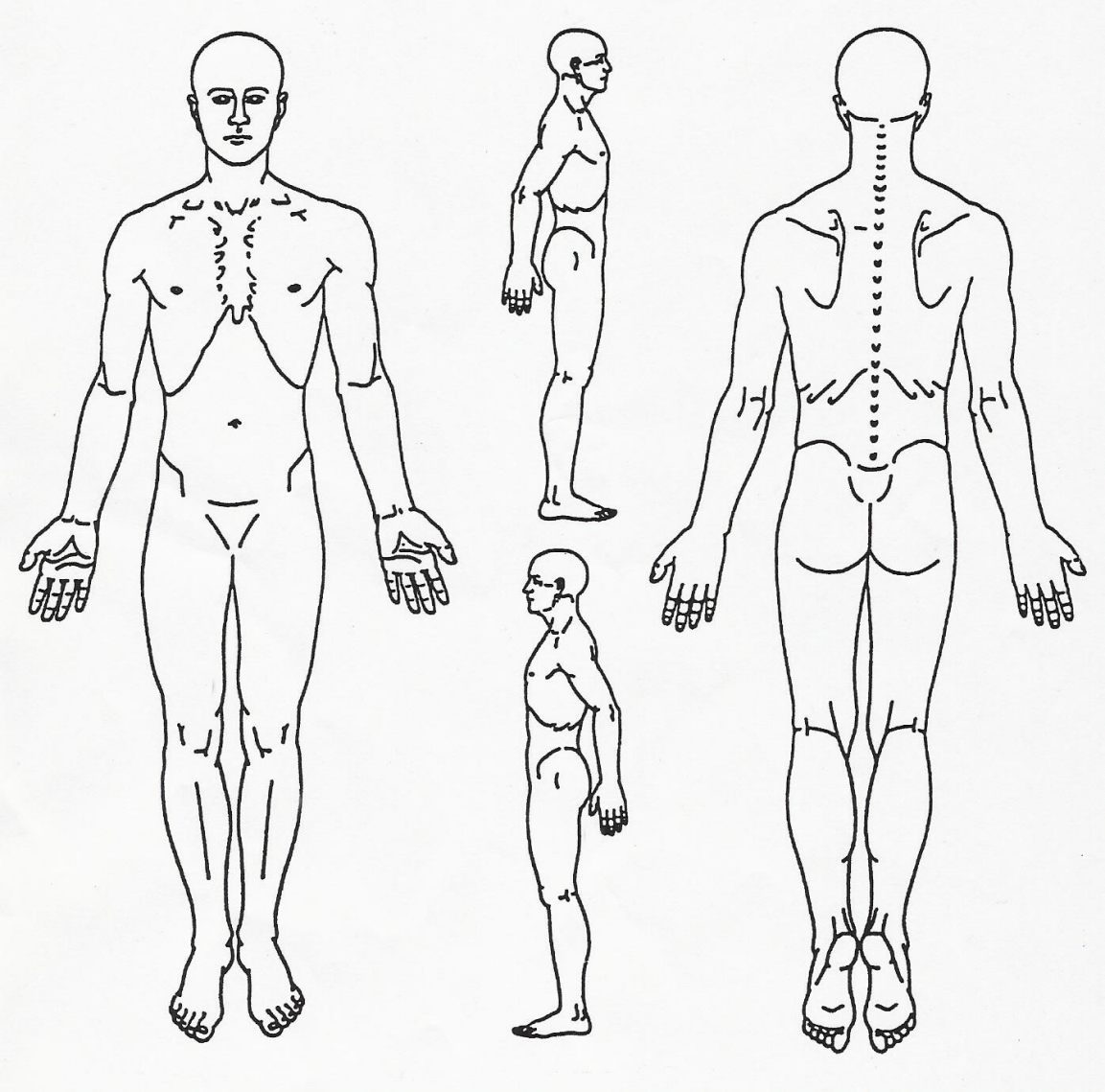
Exercise	Alcohol	Tobacco
☐ Sedentary (No exercise) ☐ Mild exercise (walking, golf) ☐ Regular vigorous exercise (4x/week)	☐ Drink alcohol ☐ Concerned about the amount you drink How many drinks per week?	☐ Use tobacco # of years? Year quit? Packs per day?
Drugs	**Sex**	**Personal Safety**
☐ Currently use recreational or street drugs ☐ Used street drugs with a needle in the past	☐ Sexually Active ☐ Trying for pregnancy	☐ Live alone ☐ Frequent falls in the last 6 months

Family Health History

	Age/Sex	Significant Health Problems		Age/Sex	Significant Health Problems
Father			Children		
Mother					
Sibling					

Pain Diagram

Please check or shade the areas where you are having pain:



Patient Education & Self-Assessment

The doctor or nurse will need to educate you about your condition and/or medication.

Please indicate if you believe any of the items listed below will interfere with your ability to learn about your condition(s) or medication(s):

- ☐ No difficulties
- ☐ I cannot hear well enough to receive verbal information
- ☐ I cannot see well enough to read printed information
- ☐ I do not speak English well
- ☐ I do not read English well
- ☐ I have trouble remembering things
- ☐ Other, please specify

Is there someone needed to interpret for you? ☐ Yes ☐ No

How do you prefer to learn? ☐ Written instruction ☐ Oral instruction ☐ Demonstrations

Are you experiencing pain or have you had pain in the past 6 months? ☐ Yes ☐ No

Do you have any dietary restrictions?

Can we leave messages regarding your test results or other medical communication?

At your home: ☐ Yes ☐ No Phone Number _____

At your work: ☐ Yes ☐ No Phone Number _____

On your cell phone: ☐ Yes ☐ No Phone Number _____

By signing below, you certify that the included information is accurate and inclusive of all information relevant to your care.

Patient Signature: _____ **Date** _____

By signing below, you certify that the included information is accurate and inclusive of all information relevant to your care.

Physician Signature: _____ **Date** _____