PATIENT MEDICAL HISTORY FORM

Today's Date: ___________________________

Patient Name: ____ Date Of Birth: _________________

Favorite Pharmacy: _________________________ Pharmacy Address: _______________________________________

Marital Status: □ Single □ Married □ Divorced □ Widowed

Last Medical Exam: ______________________________ Last Doctor: ____

Allergies: ____

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Medications (Please list both Prescribed and Non-Prescribed): ____

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Previous Medical Illness, Surgeries, or Hospitalizations: ____

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Any Medical Problems: ____

OB/GYN History – Last Mammogram: ____________________ LAST PAP: ____________________________________

Pregnancies: _____________________________ Deliveries: ____

Smoke? □Yes □ No, How Many Packs Per Day: ____ Drink? □YES □ NO How Many Oz or Glasses Per Week: _____

Any Drug Use? ____

Family History: (Check All That Apply)

____ Alcoholism	____ Anemia	____ Asthma	____ Arthritis	____ Bleed easily
____ Breast cancer	____ Colon Polyps	____ Colon Cancer	____ Diabetes	____ Glaucoma
____ Gout	____ Heart Disease	____ High BP	____ Iron Disease	____ Kidney Disease
____ Mental illness	____ Migraine	____ Osteoporosis	____ Prostate Cancer	____ Seizures
____ Thyroid Disease	____ Tuberculosis	____ Other: ______________________________		

Immunizations:

When was your last booster for?

Tetanus: ____________________ Pneumonia: ______________________ Flu Vaccine: ________________________

Advanced Directives: Please discuss with your spouse and/or family and your physician.

Do you have a living will? □YES □ NO Are you an Organ Donor? □YES □ NO

Do you have a Durable Power of Attorney for Health Care? □YES □ NO If yes, who? ___________________________

PLEASE CHECK SYMPTOMS THAT APPLY TO TODAYS VISIT

Patient Name: ____ Date of Birth: ______________________________

Reason for your visit: ____ Date: _____________________________________

Constitutional
- Fatigue
- Fever
- Chills
- Unintentional weight gain or loss

Ears/Nose/Throat
- Ear pain
- Nose Bleeds
- Nasal congestion or drainage
- Sore Throat
- Tooth Pain
- Runny Nose
- Sneezing

Eyes
- Blurred Vision
- Eye Drainage
- Eye Irritation
- Itchy Eyes

Respiratory
- Cough
- Shortness of Breath
- Chest Congestion
- Wheezing

Cardiovascular
- Chest Pain
- Palpitations

Gastrointestinal
- Abdominal Pain
- Constipation
- Diarrhea
- Nausea
- Vomiting

Genitourinary
- Painful Urination
- Frequent Urination
- Blood in Urine
- Irregular or heavy vaginal bleeding
- Vaginal discharge
- Vaginal Itching

Musculoskeletal
- Joint or Limb pain
- Joint or Limb swelling
- Joint Stiffness
- Muscle aches

Integumentary
- Rash
- Itching

Neurological
- Headache
- Numbness
- Weakness

Psychiatric
- Anxiety
- Depression

Endocrine
- Heat or cold intolerance
- Excessive Thirst
- Excessive Urination

Hematologic/Lymphatic
- Easy Bruising or Bleeding
- Swollen Glands

Grand Prairie Urgent Care & Family Medicine

Miscellaneous Instructions and Information for Discharge

Patient Name: ______________________________________ Date: _________________________________

Patient DOB: ___________________________________ MRN: _____________________________________

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- If you are not feeling better in ___ days, please return to the clinic for further evaluation
- If you are not feeling better in ___ days contact your primary care provider to schedule a follow up appointment
- If new or worsening symptoms occur contact your primary care provider immediately or go to the nearest ER
- Please allow up to 24 hours for all medication refill request to be processed
- Please allow up to 3 business days for Lab or imaging results to be reviewed by the provider for interpretation

My signature indicates my acknowledgement that my discharge instructions and continued home treatment has been explained to me as the patient or legal guardian of the patient by a clinical staff member.

Provider Signature: __________________________ Patient/Guardian Signature: ___________________________