



# Urgent Care Center

TLC Urgent Care Center

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TLCurgentcarecenter.com

## Patient Medical History

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ (Nickname)

Date of birth: \_\_\_\_\_ Age:  Sex: M F

Reason for today's visit: \_\_\_\_\_

Drug Allergies	None
_____	
_____	
_____	
List attached	Continued on other side

Current Medications:	None
_____	
_____	
_____	
_____	
List attached	Continued on other side

Hospitalization or Surgery	None
Reason _____	Date _____
_____	_____
_____	_____
List attached	Continued on other side

Family History	Father	Mother	Father's Parents	Mother's Parents	_B_S Sibling	_S_D Child
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Osteoporosis						
Diabetes						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Alzheimer's Disease						
Parkinson's Disease						

Habits:
<b>Smoke:</b> Packs daily _____ / How long? _____ If quit, when? _____ / Interested in stopping? Yes No
<b>Exercise Routine:</b> _____
<b>Coffee:</b> Cups daily _____ / Other caffeine _____
<b>Alcohol:</b> Type _____ / Amount _____
<b>Sleep:</b> Difficulty falling asleep _____ Continuity Disturbances _____ Daytime drowsiness _____ Sleep Apnea HX _____ Snoring _____ Early Morning Awakening _____

**MEN only:** Has anyone in the family has testicular or prostate cancer? Yes No

**WOMEN only:**  
Pregnant? Yes No Planning pregnancy? Yes No  
Has anyone in the family had breast, ovarian, uterine, cervical or Vulva cancer? Yes No  
Last day of Menstrual Period: \_\_\_\_\_ Regular Irregular  
Menopause: Yes No How many years ago? \_\_\_\_\_

Hepatitis C Risk Factor:	
Blood transfusion prior to 1992	Tattoos
Contact with blood/bodily fluid	Body Piercing
Shared razor/toothbrush	History of STDs / TB
History of Hepatitis B	IV Drug use (1+ times)

Medical History (check all that apply)			
Headache	Lactose Intolerance	Osteoporosis	Diabetes _____ years
Shortness of Breath	Gallbladder Disease	Nervousness / Anxiety /	HIV / AIDS
Heart Palpitations	Prostrate Disease	Panic Attack	Stroke
Heart Murmur	Bowel Irregularity / IBS	Depression	Memory Loss
Chest Pain	Urinary Incontinence	Gout	TB / Lung Disease
Dizziness / Fainting	Sexual Menstrual Dysfunction	Chronic Rashes / Hives	Hypertension _____ years
Heart Attack	Venereal Disease (STDs)	Rheumatic Fever	High Cholesterol
Allergies / Hay Fever	Frequent Infections	Seizure Disorder	Glaucoma / Cataract
Asthma	Hepatitis A / B / C	Congestive Heart Failure	_____
Bronchitis	Liver Disease / Cirrhosis	Emphysema / COPD	_____
Pneumonia	Rheumatoid Arthritis	Blood Clots / DVT	_____
Stomach Ulcer	Osteoarthritis	Anemia	_____
Cancer _____	Kidney Disease	Leg Swelling	_____

Signature of Patient (or Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_