

**PALM COAST URGENT CARE
COMPREHENSIVE MEDICAL HISTORY**

DATE _____

PATIENT'S NAME _____ SOCIAL SECURITY _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: _____

PLEASE LIST ANY ALLERGIES YOU HAVE TO MEDICATIONS: _____

PLEASE CHECK IF ANY **BLOOD RELATIVES** HAVE SUFFERED ANY OF THE FOLLOWING CONDITIONS, PLEASE INDICATE WHICH RELATIVE IN THE SPACE PROVIDED

DIABETES _____ HYPERTENSION _____
HIGH CHOLESTEROL _____ HEART ATTACK _____

PLEASE CHECK IF YOU HAVE OR HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS

| | NO | YES | EXPLAIN |
|------------------------|-------|-------|---------|
| HIGH BLOOD PRESSURE | _____ | _____ | _____ |
| DIABETES | _____ | _____ | _____ |
| HYPOGLYCEMIA | _____ | _____ | _____ |
| THYROID PROBLEMS | _____ | _____ | _____ |
| STOMACH PROBLEMS | _____ | _____ | _____ |
| HIATAL HERNIA | _____ | _____ | _____ |
| ULCER (PEPTIC) | _____ | _____ | _____ |
| BOWEL DISORDER | _____ | _____ | _____ |
| KIDNEY PROBLEMS | _____ | _____ | _____ |
| GALL BLADDER DISEASE | _____ | _____ | _____ |
| LIVER DISEASE | _____ | _____ | _____ |
| RESPIRATORY PROBLEMS | _____ | _____ | _____ |
| COUGH (CHRONIC) | _____ | _____ | _____ |
| SHORTNESS OF BREATH | _____ | _____ | _____ |
| HEART PROBLEMS-SURGERY | _____ | _____ | _____ |
| OTHER SURGERIES | _____ | _____ | _____ |
| ANKLE SWELLING | _____ | _____ | _____ |
| ANEMIA | _____ | _____ | _____ |
| BLOOD DISORDERS | _____ | _____ | _____ |
| VARICOSE VEINS | _____ | _____ | _____ |
| CANCER | _____ | _____ | _____ |
| EYE PROBLEMS | _____ | _____ | _____ |
| HEARING PROBLEMS | _____ | _____ | _____ |
| OTHER | _____ | _____ | _____ |

FOR WOMEN ONLY: ARE YOU PREGNANT? YES _____ NO _____ UNCERTAIN _____

DATE OF LAST MENSTRUAL PERIOD _____

HYSTERECTOMY YES _____ DATE OF PROCEDURE _____ NO _____

TOBACCO: CIGARETTES _____ PIPES _____ CIGARS _____ AMT/ DAY _____ YRS SMOKING _____

ALCOHOLIC BEVERAGES: DAILY _____ WEEKEND _____ NEVER _____
TYPE CONSUMED _____ AMOUNT _____ HOW LONG _____

SUBSTANCE ABUSE: CURRENT _____ PREVIOUS _____
SUBSTANCE ABUSED _____

ALL OF THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE OF PATIENT OR GUARDIAN _____