APEX URGENT CARE
CONVENIENT, COMPASSIONATE, CARE

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Medical History Questionnaire

What is the reason for today's visit? _____

Do you have any allergies? (Environmental and/or medications) ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had a reaction to Novacaine, Lidocaine, iodine, bandages, or topical antibiotics (Neosporin)? ☐ Yes ☐ No

Are you Pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Please list below current medications you are taking (including prescriptions, over the counter meds, vitamins, herbal supplements):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever had in the PAST or do you currently have NOW:

Bronchitis	☐Past ☐Now	Aneurysm	☐Past ☐Now	Kidney/Renal Disease	☐Past ☐Now
Allergic Rhinitis	☐Past ☐Now	Stroke or TIA	☐Past ☐Now	Dialysis or Renal Failure	☐Past ☐Now
Sinusitis	☐Past ☐Now	Fainting	☐Past ☐Now	UTI/Bladder or Kidney Infection	☐Past ☐Now
Ear Infection	☐Past ☐Now	Seizures	☐Past ☐Now	Kidney Stones	☐Past ☐Now
Emphysema/COPD	☐Past ☐Now	Anxiety	☐Past ☐Now	STD or Pelvic Infections	☐Past ☐Now
Asthma	☐Past ☐Now	Depression	☐Past ☐Now	HIV/AIDS/HIV Disease	☐Past ☐Now
Lung Disease	☐Past ☐Now	Bipolar Disorder	☐Past ☐Now	Ovarian Cyst	☐Past ☐Now
High blood pressure	☐Past ☐Now	ADD/ADHD	☐Past ☐Now	Enlarged Prostate or Prostatitis	☐Past ☐Now
Heart Disease	☐Past ☐Now	Thyroid Disease	☐Past ☐Now	Gallstones/Gallbladder Disease	☐Past ☐Now
High Cholesterol	☐Past ☐Now	Arthritis	☐Past ☐Now	Intestinal or Colon Problems	☐Past ☐Now
Diabetes	☐Past ☐Now	Gout	☐Past ☐Now	Diverticulosis/Diverticulitis	☐Past ☐Now
Blood Clots/DVT	☐Past ☐Now	Artificial Joints	☐Past ☐Now	Pancreatitis	☐Past ☐Now
Bleeding Disorder	☐Past ☐Now	Fibromyalgia	☐Past ☐Now	Peptic Ulcer Disease	☐Past ☐Now
Inflammation of Veins	☐Past ☐Now	Back Problems	☐Past ☐Now	Heartburn or Acid Reflux	☐Past ☐Now
Migraines	☐Past ☐Now	Anemia	☐Past ☐Now	Liver Disease or Hepatitis	☐Past ☐Now
Recurrent Headaches	☐Past ☐Now	Cancer	☐Past ☐Now	Skin disorders/Eczema	☐Past ☐Now

I have no history of significant medical problems: ☐ **Yes** **Immunizations up to date?** ☐ Yes ☐ No

List any other diseases or conditions: _____

Surgeries: ☐ **I have not had any surgery**

☐ Appendectomy ☐ Pacemaker ☐ Back surgery ☐ Tonsillectomy Any other surgeries? ☐ Yes ☐ No

☐ Gallbladder ☐ Hysterectomy ☐ Heart Bypass Please specify: _____

Social History:

Do you now or have you ever used alcohol? ☐ Regularly ☐ Occasionally ☐ Rarely/Once ☐ **No**

Do you now or have you ever used tobacco? ☐ Yes (# Packs a day: _____) ☐ Quit (Year:_____) ☐ **No**

Do you use any drugs (including marijuana)? ☐ Regularly ☐ Occasionally ☐ Rarely/Once ☐ **No**

Family History:

	None	Diabetes	High Blood Pressure	Heart Disease	Other:
Mother	☐	☐	☐	☐	_____
Father	☐	☐	☐	☐	_____
Sister	☐	☐	☐	☐	_____
Brother	☐	☐	☐	☐	_____
Grandmother	☐	☐	☐	☐	_____
Grandfather	☐	☐	☐	☐	_____

Name_____ DOB____ / ____ / _____ Date____ / ____ / _____