Urgent Care
New Smyrna Beach | Ormond Beach

Patient Name: _____DOB:_____SEX: Male / Female

**REASON FOR VISIT TODAY**:_____

Current **MEDICATIONS** over the counter **or** Prescription **MEDICATIONS** that you are taking currently:

_____

_____

_____

Please list anything you may be **ALLERGIC** to and what kind of reaction you have:

_____

Have you or a family member have or ever had any of the following diseases or conditions? Please circle **F**-for family history or **P**- for personal history of condition
(**PLEASE INCLUDE RELATION TO FAMILY MEMBER)**

| | | |
|---|---|---|
| **F/P** High Blood Pressure | **F/P** High Cholesterol | **F/P** Thyroid |
| **F/P** Heart Attack / Stroke | **F/P** Heart Surg / Pacemaker | **F/P** Heart Murmur |
| **F/P** Artificial Valves | **F/P** Congenital Heart Defect | **F/P** Mitral Valve Prolapse |
| **F/P** Hepatitis | **F/P** Venereal Disease | **F/P** HIV / AIDs |
| **F/P** Emphysema | **F/P** Shingles | **F/P** Anemia |
| **F/P** Glaucoma | **F/P** Sinus Problems | **F/P** Kidney Problems |
| **F/P** Severe Headaches | **F/P** Diabetes | **F/P** Arthritis OA/RA |
| **F/P** Difficulty Breathing | **F/P** Lower Back Problems | **F/P** Psychiatric Problems |
| **F/P** Artificial Bones/Joint | **F/P** Alcohol/ Drug Abuse | **F/P** Chemotherapy |
| **F/P** Ulcers/ Colitis | **F/P** Tuberculosis* | **F/P** Cancer * |

TB- Were you treated for TB. If so,When? _____with what medication_____ .
Cancer- Who had Cancer and what kind?_____.

Please list any SURGERIES and dates:_____.
_____.

Date of last Menstrual Cycle? _____Any Chance of Pregnancy?_____Prior Pregnancies#_____
#Deliveries_____ Any complications with Pregnancies_____

**Socially**
Do you **SMOKE**? Yes/ No If Yes, how many Packs per day? _____
Do you **DRINK**? Yes/ No How much a day? _____ When was your last **TETANUS** Shot? _____

**Child Immunization up To Date: _____Yes _____ No**

**CONFIDENTIALITY: INFORMATION WILL NOT BE RELEASED UNLESS YOU HAVE AUTHROIZED US TO DO SO**