Neighborhood Urgent Care
Health Information Questionnaire

Today's Date: _____ Primary Care Provider:_____

Patient's Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Name:_____ Telephone Number:_____

What is the reason for your visit today? _____

What medications are you currently taking? (Attach list if Necessary)

Medication:	Prescribed by:	Do you need a refill today?

Are you allergic to any medications? ☐ Yes ☐ No If yes, what medication?_____
What type of reaction did you have to this medication ? _____
Are you currently pregnant or nursing? _____
Last Menstrual Period/Hysterectomy _____

Please check any symptoms below that you are currently experiencing:

Constitutional:
____ Fever/Chills
____ Feeling poorly
____ Feeling tired
____ Recent weight gain/loss
____ Night sweats

Eyes:
____ Eye Pain
____ Red eyes/Discharge
____ Vision changes
____ Dry eyes
____ Itchy eyes

ENT:
____ Earache
____ Sore throat
____ Nasal congestion
____ Nosebleeds
____ Hoarseness
____ Hearing loss

Cardiovascular:
____ Chest pain
____ Irregular heart beat
____ Lower extremity edema
____ Leg cramps
____ Slow heart rate
____ Fast heart rate

Gastrointestinal:
____ Nausea and/or Vomiting
____ Abdominal pain
____ Diarrhea
____ Heartburn

Genitourinary:
____ Trouble swallowing
____ Dark or bloody stool
____ Pain with urination
____ Frequency Urgency of urination
____ Night time urination
____ Hesitancy
____ Incontinence (loss of urine control)
____ Blood in urine
____ Genital lesion
____ Difficulty with menstrual periods (females)
____ Erectile dysfunction (males)

Neurological:
____Headache
____Dizziness
____ Mental changes
____ Fainting
____ Limb weakness
____ Difficulty walking
____ Numbness
____ Tremor
____ Tingling

Respiratory:
____ Shortness of breath
____ Shortness of breath during exertion
____ Shortness of breath with lying down/ at night

Psychiatric:
____ Anxiety
____ Depression
____ Suicidal or homicidal thought
____ Personality changes/Irritability
____ Sleep disturbances

Endocrine:
____ Excessive thirst/urination
____ Drooping of eyelid
____ Hot or cold intolerance
____ Hair loss
____ Generalized weakness

Blood/Lymph:
____ Easy bruising/bleeding
____ Swollen glands

Integumentary:
____ Skin rash
____ Itching
____ Skin lesions
____ Change in a mole
____ Breast pain/lump
____Wound/Unusual growth on the skin

Patient Name: _____ Date of Birth: _____

Marital Status ☐ Single ☐ Married ☐ Divorced Number of Children: _____ Number of pregnancies: _____

Past Medical History:

Have you been treated for any of the following conditions? If so, please list approximate dates of treatment and treating physician.

Condition:	Approximate Dates of Treatment:	Treating Provider:
Anemia		
Anxiety		
Arthritis		
Blood Disease		
Cancer		
Cholesterol		
Depression		
Diabetes		
GI Disease		
Genital/Urinary Disease		
Glaucoma		
Heart Disease		
High blood pressure		
Liver Disease		
Lung Disease/Asthma		
Seizures		
Stroke		
Thyroid Disease		
Weight		
Serious Accident:		
Other:		

Past Surgeries:

Surgery	Approximate Dates of Treatment	Surgeon/Hospital

PATIENT QUESTIONNAIRE

Patient Name _____ Date ____/___/____

Family History

Use √ to indicate positive history and approximate age

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Diabetes									
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									
Liver Disease									
Depression or manic Depressive disorder									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Migraines									
Thyroid problems									
Other									

Social History

Tobacco Use:

Ever used tobacco? ☐ Yes ☐ No If yes: Year started using _____

Still using tobacco? ☐ Yes ☐ No If no: Year quit using _____

Type of tobacco used (check all that apply) ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Snuff/Chew

Alcohol use ☐ Never ☐ Daily ☐ Occasional

Illegal Drug Use ☐ Yes ☐ No If yes, describe _____

Other Physicians and Providers of Care

Name & specialty/provider type	Type of care	Date of last visit

Advance Directive

Do you have a healthcare Power of Attorney? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

If yes, please bring a copy to your visit.