AllSouth Urgent Care, Inc.
MEDICAL HISTORY

Name: _________________________________ **Age**: ________ **Date of Birth**: __________________________

Primary Care Physician: __________________________**Specialty Physician**: ____________________________

Please indicate if you have a history of any of the following:

( ) Alcohol/Drug Addiction
( ) Anemia
( ) Arthritis:
  ( ) Rheumatoid
  ( ) Osteoarthritis
( ) Asthma
( ) Broken Bones/Fractures
( ) Cancer
( ) Chest Pain
( ) Diabetes
( ) Emphysema/COPD
( ) Enlarged Prostate
( ) Epilepsy/Seizures
( ) Heart Attack
( ) Heart Disease
( ) Heart Murmur
( ) Hemophilia/HIV
( ) Hiatal Hernia
( ) High Blood Pressure
( ) Jaundice/Hepatitis
( ) Kidney Disease
( ) Liver Disease
( ) Mitral Valve
( ) Stroke
( ) Thyroid Problems
( ) Ulcers
( ) Unusual weight loss/gain past year
( ) Urine Infections

Please list any previous surgical procedures and year performed:

_______________________________________ _____________________________________

_______________________________________ _____________________________________

_______________________________________ _____________________________________

_______________________________________ _____________________________________

Are you allergic to any of the following:

( ) Cephalosporin
( ) Penicillin
( ) Sulfa Drugs
( ) other ___________________________

Do you have a family history of:

( ) Heart Disease ____________________________
( ) Diabetes _______________________________

Do you smoke? ( ) Yes ( ) No
Drink alcohol/wine/beer? ( ) Yes ( ) No __ per day

Please list any medications, vitamins, or over-the-counter drugs you take:

_________________________ Dosage: ________ Frequency: ________
_________________________ Dosage: ________ Frequency: ________
_________________________ Dosage: ________ Frequency: ________
_________________________ Dosage: ________ Frequency: ________

Anything else you feel would be important for your doctor to know about you: _______________________
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