COASTAL MED Urgent Care

NEW PATIENT MEDICAL HISTORY FORM

Full Name: _____ Date: _____

Address:_____Apt/Ste: _____ Zip Code: _____

Date of Birth :_____ Phone Number: _____ Email:_____

Reason for Visit:_____

ALLERGIES

o **NO ALLERGIES**

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS	DOSE	TIMES PER DAY

SURGERIES

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/ Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			

Migraine Headaches			
Stroke			

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation: _____ Age of Menopause: _____

SOCIAL HISTORY

Occupation *(or prior occupation)*:	o Retired o Unemployed o LOA o Disabled
Employer:	Years of Education or Highest Degree:
Marital Status *(check one)*: o Single o Partner o Married o Divorced o Widowed o Other:_____	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	o Beer o Wine o Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N			

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?

EMERGENCY CONTACT

NAME	PHONE NUMBER

PREFERRED PHARMACY

NAME	ADDRESS/PHONE NUMBER

PRIMARY CARE PHYSICIAN

NAME	PHONE NUMBER/FAX

*FOR CLINICIAN USE ONLY

VITALS

Height: _____ Heart Rate: _____ Temp: _____

Weight: _____ BP: _____ Oxygen Sat:_____