

MIDLANDS FAMILY URGENT CARE

312 Olson Drive, Suite 101
Papillion, NE 68046

HEALTH HISTORY FORM

Patient Name: _____ **DOB:** _____

In order to provide the best care possible at Midlands Family Urgent Care, your provider needs to know your health history. This information is a confidential part of your medical record and is used to help with your diagnosis and treatment. Please answer the following questions to the best of your knowledge.

1. Does the patient have any chronic conditions? YES NO (ie: asthma, high blood pressure, diabetes...etc. Anything that requires daily/regular medications)

2. Has the patient had any surgeries? YES NO If yes, type and dates:

3. Is the patient taking any medications? YES NO (THIS INCLUDES PRESCRIPTION, VITAMINS, HERBS, AND OVER THE COUNTER MEDICATIONS.)

*****Please make sure ALL CONDITIONS that medications are being taken for are listed above.*****

If you carry a list of medications taken, please provide and we can copy.

Medication Name: (If more space is needed, use the back of this page.)

Dose/frequency: _____

4. Family History: (List Relatives with any of the following problems and if outside of immediate family, please indicate if Maternal or Fraternal side)

Heart Disease: _____

High Blood Pressure: _____

Diabetes Type 1: _____ Diabetes Type 2: _____

Respiratory Disease: _____

Cancer: _____

Emotional Problems: _____

Other Inherited Diseases: _____

5. Does the patient have any drug allergies? YES NO

Medication/Type of Reaction _____

Medication/Type of Reaction _____

Medication/Type of Reaction _____

Medication/Type of Reaction _____

6. Health Habits: (Circle most appropriate)

Tobacco Use: Never Rarely Frequently For how long? _____ How much do you smoke a day? _____

Alcohol Use: Never Rarely Frequently

Street Drugs: Never Rarely Frequently

For Minors:

Does anyone in the household they currently live in smoke? YES NO