Advanced Medical Center

MEDICAL INFORMATION FORM - ADVANCED URGENT CARE

Please provide the following information to your physician.

Date: _____

Name: _____

Primary Care Physician: _____

Reason for today's visit: _____

_____

REVIEW OF MEDICAL SYSTEMS

(Check all that apply to you.)

☐CHEST PAIN/PRESSURE ☐HIGH BLOOD PRESSURE ☐HEART ATTACK ☐STROKE ☐HEADACHES ☐GLAUCOMA ☐DEPRESSION ☐ARTHRITIS
☐COUMADIN/PLAVIX USE ☐ASTHMA ☐SHORTNESS OF BREATH ☐CHRONIC LUNG DISEASE ☐DIZZY SPELLS ☐DIFFICULTY HEARING
☐URINARY INFECTIONS ☐KIDNEY STONES ☐KIDNEY DISEASE ☐BLOOD CLOTS ☐DIABETES ☐CHRONIC BACK PAIN ☐SKIN DISORDERS
☐BLOOD DISORDER ☐BLOOD CLOTTING ABNORMALITIES ☐HEART VALVE REPLACEMENT ☐CANCER (type)_____
☐INFECTION (type) _____ ☐HEPATITIS (type) _____ ☐OTHER
_____

FAMILY HISTORY

(Major illnesses and history of significant disease of GI tract, liver, pancreas, etc.)

Father _____ Mother _____

Sister _____ Brother _____

Other

QUESTIONNAIR

Do you use chewing tobacco now? ☐Y ☐N Amount:_____ How Long?_____

Do you smoke now? ☐Y ☐N Amount:_____ How Long?_____

Former smoker? ☐Y ☐N When did you quit (month/year)? _____

Alcohol Intake (circle one) Daily Weekly Monthly Never

Caffeine Intake (circle one) Daily Weekly Monthly Never

Last menstrual period: _____

List all current or recently used medications: _____

List medications used not prescribed to you or recreational drugs, if applicable: _____

Have you had any allergies or sensitivities to medications or other substances? ☐Y ☐N Please list all:

Please list any past medical problems: _____

Please list all surgeries or hospitalizations: _____

PHYSICIAN REVIEW

Signature: **Date:**