Walking Urgent Care, Inc
10308 W Sample Road
Coral Springs, FL 33065
954-755-4880

NEW PATIENT HISTORY QUESTIONNAIRE

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Place of Birth (State, Country):** _____

Where would you like your prescriptions sent today? Pharmacy name & location: _____

How did you hear about us(check): ☐ **Yellow Pages,** ☐ **Internet,** ☐ **Friend/Family, Other** _____

Reason For Today's Visit _____

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following (check all that apply)?

☐ Asthma	☐ High Blood Pressure	☐ Diabetes	☐ Liver Disease
☐ Heart Murmur	☐ Heart Disease	☐ High Cholesterol	☐ Gout
☐ Seizure	☐ Irregular Heart Beat	☐ Blood clot in leg or lung	☐ Glaucoma
☐ Migraine	☐ Carotid artery stenosis	☐ Syncope(passed out)	☐ HIV
☐ Tuberculosis	☐ Kidney disorder	☐ Seasonal allergies	☐ Syphilis
☐ Depression	☐ Bipolar disorder	☐ Arthritis	☐ Herpes
☐ Stroke/CVA/TIA	☐ Anxiety	☐ Concussion	☐ Gonorrhea

Cancer: (list type and date diagnosed) _____

1. **Have you ever had a positive TB (tuberculosis), PPD or TINES test?** ◯ **Yes** ◯ **No**
2. **Have you ever had a blood transfusion?** ◯ **Yes** ◯ **No**
3. **Have you ever been admitted to the hospital?** ◯ **Yes** ◯ **No**

   If yes, for what? _____

Please list all medications, vitamins, herbal products and/or nutritional supplements you take

_____

_____

List allergies to medicines or food: _____

FEMALES

Last menstrual period: _____ **# of Pregnancies:** ____ **Last Pap:** _____ **Last Mammogram:** _____

Have you ever had an abnormal Pap or Mammogram? ◯ **Yes** ◯ **No**

FAMILY HISTORY

Any family member(mom, dad, brothers, sisters, grandparents)with any of the following(please circle):

☐ High Blood Pressure	☐ Diabetes	☐ High Cholesterol	☐ Stroke
☐ Heart attack	☐ Seizures	☐ TIA	☐ Aneurysms

Sudden Death (before 45 years old?) ◯ **Yes** ◯ **No**

Cancer (who & what type?) _____

Do you smoke: ◯ **Yes** ◯ **No** **Drink alcohol:** ◯ **Yes** ◯ **No** **Street Drugs:** ◯ **Yes** ◯ **No**