

LONG POINT URGENT CARE

Patient: _____ Company: _____ Date of Service: _____
Patient ID: _____ Contact: _____
Birthdate: ___/___/___ Age: _____ Form: HEALTHX Page 1

HEALTH HISTORY

Please list any past medical problems/conditions that you have experienced.
(Example: High Blood Pressure, Kidney problems, Liver problems, Breathing problems, Diabetes, etc...)

Do you have any vision or eye problems? No ___ Yes ___
Do you wear glasses or contact lenses? No ___ Yes ___
Explain: _____

Have you ever had any work related injuries or illnesses? No ___ Yes ___
What type? _____ When? _____
Did you lose time? No ___ Yes ___

Have you ever had any other surgery or serious injuries or major hospitalizations?
No ___ Yes ___ What type? _____
When? _____

Have you ever been denied employment, military service, or been unable to work due
to injury? No ___ Yes ___
Have you received disability payments? No ___ Yes ___

Are you allergic to any medications? No ___ Yes ___
Please list them: _____

Are you currently taking any medications? No ___ Yes ___
Please list them: _____

When was your last TB Test/PPD? _____ Results: _____
When was your last Tetanus booster? _____ Allergic Reaction? No ___ Yes ___
Have you had Measles, Mumps, Rubella vaccine? No ___ Yes ___
Have you had Hepatitis B Vaccines? No ___ Yes ___ How many? _____ When? _____
Have you had Hepatitis A Vaccine? No ___ Yes ___ When? _____

History of illnesses in Mother, Father or close blood relative
Bleeding Problems: Mom ___ Dad ___ Other ___
Diabetes/Sugar: Mom ___ Dad ___ Other ___
High Blood Pressure: Mom ___ Dad ___ Other ___
Cancer/Tumor: Mom ___ Dad ___ Other ___
Heart Trouble: Mom ___ Dad ___ Other ___
Tuberculosis: Mom ___ Dad ___ Other ___

Social Health History:
Do you now use or did you in the past use?
Cigarettes: ___ Chewing Tobacco: ___
Marijuana/Pot: ___ Cocaine/Heroine: ___
Beer: ___ Other: ___
Comments: _____

All information given above is complete and accurate.
Signature: _____