www.mylocalurgentcare.net

PATIENT'S NAME : ______________________________________ **TODAY'S DATE :** _______________________________

DATE OF BIRTH :_______________________________ **CURRENT PHONE NUMBER:**________________________________

Reason for today's visit :

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List of current medications : **Must have current dosages and frequency of use.**

IF YOU DO NOT KNOW PLEASE CONTACT YOUR PHARMACY.

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If you do not take any prescribed Medication please check here. ☐

List all allergies :

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Any medical history change or surgery since previous visit?

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Female: When was the first day of your last menstrual period? __/__/____

Do you currently smoke or chew tobacco? ○ Yes ○ No If yes, how many packs/cans a day?______ If no, have you in the past? ○ Yes ○ No

Do you drink alcohol? ○ Yes ○ No If yes, how many drinks per week?_______ If no, have you in the past? ○ Yes ○ No