MT. AUBURN URGENT CARE

History and Physical

Patient Name: _____ Date: _____ MR#_____

Date of Birth: ___/___/____ Sex: M___ F___

Primary Physician: _____ Phone: _____ Last MD Visit: _____

Why are you here?_____

_____

_____

MEDICATION ALLERGIES: _____

PAST MEDICAL HISTORY	CURRENT MEDICATIONS (INCLUDING OVER THE COUNTER)	
Surgeries:	**Medication List:**	
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
Illness:	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
Hospitalizations:	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
	Dose/freq	Indication
Social History:	Dose/freq	Indication
Alcohol: Daily_____ Amount_____	Dose/freq	Indication
Drugs:	Dose/freq	Indication
Tobacco: ppd____ x _____yrs	Dose/freq	Indication
Assistive Devices:	Dose/freq	Indication
Wheelchair	Dose/freq	Indication
Cane: Other:	Dose/freq	Indication
FAMILY HISTORY:		

Patient Name: _____ MR#_____ Date: _____

Chronic Condition List/Review of Systems

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Alcohol/Drug Use			Irregular Heart Rate/ Rhythms			**RESPIRATORY DISEASE**			**PARALYSIS**		
Tobacco Use			Pacemaker			COPD			Spinal Cord Disease		
Amputation			Other			Emphysema			Paraplegia		
Anemia			**CIRCULATORY VASCULAR DISEASE**			Bronchitis			Quadriplegia		
Easy Bruising			Edema			Asthma					
Cataracts Glaucoma			CVA/TIA			Chronic Cough			**INFECTIOUS DISEASES**		
Loss of Vision			Leg pain (claudication)			Short of Breath			HIV		
Loss of Hearing						Wheezing			HPV		
Enlarged lymph nodes			**GASTROINTESTINAL SYSTEM**			Oxygen Dependence			Other		
Rheumatic Fever			Ulcers						Fever		
Dizziness or Fainting			Chronic Hepatitis						Chills		
			Chronic Hepatitis B			**MUSCULOSKELETAL DISEASES**			Night Sweats		
Surgeries			Chronic Hepatitis C			Bone/joint Pain					
Ostomy/Artificial Openings			Ulcerative Colitis			Rheumatoid Arthritis (RA)			**TUMOR,NODE CANCER**		
ENDOCRINE			Crohns' Disease			Osteoarthritis			Chemotherapy		
Thyroid Disease			Celiac Spur			Fractures			Radiation		
Frequent Urination			Nausea			Limited Range of Motion					
Excessive Thirst			Coughing up blood			Recurrent Back Pain/Injury					
Temperature Intolerance			Vomiting								
SKIN DISEASES			Constipation								
Ulcers			Diarrhea			**NEUROLOGICAL DISORDERS**					
Cancer			**KIDNEY DISEASE**			Seizures/ Epilepsy					
Rash			Stones			Multiple Sclerosis					
Itching			Blood in urine			Parkinson's					
HEART DISEASE			Chronic Kidney Disease			Headaches					
High Blood Pressure			Frequent urination			Memory loss					
Chest pain			Incontinence			Confusion					
CHF						Seizures					
MI			**GYN**			Dizziness					
Angina			Abnormal Bleeding								
Palpitations			CURRENT PREGNANCY								

Patient Signature:_____ Date:_____