Gwinnett URGENT CARE & Family Practice

Patient Name:

Today's Date: Date of Birth:

PLEASE MARK ALL THAT APPLY

Medical History		
Anxiety	YES	NO
Arthritis	YES	NO
Asthma	YES	NO
Cancer	YES	NO
Congestive Heart Failure	YES	NO
COPD	YES	NO
Coronary Artery Disease	YES	NO
Depression	YES	NO
Diabetes	YES	NO
Epilepsy	YES	NO
GERD	YES	NO
GI Ulcer	YES	NO
Gout	YES	NO
Hepatitis	YES	NO
High Blood Pressure	YES	NO
High Cholesterol	YES	NO
HIV	YES	NO
Migraines	YES	NO
Renal Disease	YES	NO
Stroke	YES	NO
Thyroid Disorder	YES	NO
Tuberculosis	YES	NO
Other:		

Current Medications: (Please include dose)

Medical Allergies:

Surgical History:	YEAR

Family History		
Father:		
Is your father alive:	YES	NO
If No, please list the cause of death:		
Cancer	YES	NO
Diabetes	YES	NO
High Blood Pressure	YES	NO
Heart Disease/attach	YES	NO
Lung Disease	YES	NO
Renal Disease	YES	NO
Other:		
Mother:		
Is your mother alive:	YES	NO
If No, please list the cause of death:		
Cancer	YES	NO
Diabetes	YES	NO
High Blood Pressure	YES	NO
Heart Disease/attack	YES	NO
Lung Disease	YES	NO
Renal Disease	YES	NO
Other:		
Children:	YES	NO
How many children do you have?		
Cancer	YES	NO
Diabetes	YES	NO
High Blood Pressure	YES	NO
Heart Disease/attach	YES	NO
Lung Disease	YES	NO
Renal Disease	YES	NO
Other:		
Social History:		
Cigarettes	YES	NO
How many per day:		
Dip/Tobacco	YES	NO
How many per day:		
Alcohol Beer Wine Liqour None		
How many per day:		
Ilicit Drug Use:	YES	NO
Last Used:		