

Encompass Urgent Care – Happy Valley

New Patient Medical History

Name: _____ Birth Date: _____ Today's Date: _____

The information requested below will assist us in treating you safely. Information provided below will be kept confidential unless permission is granted or requested by law.

Reason for Today's Visit: _____

Past Hospitalizations/Surgeries: _____

Who is your primary care provider/healthcare professional? _____

What is your occupation? _____

Current Smoker? No Yes. Past smoking history: _____ # of packs per day. How many years? _____

Alcohol Intake? No Yes. If yes, how much and how often? _____

Females: Last Menstrual Period _____ Possibly Pregnant No Yes Do Not Know Due Date _____

Allergies to Medications/Foods/Other agents:

Medication	Reaction or Side Effect	Medication	Reaction or Side Effect

Current Medications: Including prescription, over-the-counter, vitamins, and birth control pills:

Medication	Dose	Frequency	Medication	Dose	Frequency

Medical History:

- | | | |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart disease/Heart attack | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Stroke/CVA | <input type="checkbox"/> Liver disorder/disease | <input type="checkbox"/> Chronic pain |
| <input type="checkbox"/> Pacemaker or similar device | <input type="checkbox"/> Kidney disorder/disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Skin condition |
| <input type="checkbox"/> COPD/Emphysema | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Chronic cough/Shortness of breath | <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Pneumonia/Bronchitis | _____ | |