PERSONAL HEALTH HISTORY

HEATHROW URGENT CARE
1125 Town Park Ave., Suite 1011
Heathrow, FL 32746
407.804.9494
Fax 407.804.9443

Name: _____ **DOB:** _____ **Date:** _____

History / Chief Complaint:

1. What is the reason for your visit? _____
2. When did this symptom first start? _____
3. (If it occurred at work)... Please describe how you were injured: _____

_____

_____

Past Medical History: Have you ever had - Circle Yes or No

Asthma	Y	N	Kidney Problems	Y	N
Back Pain	Y	N	Liver Disease	Y	N
Cancer	Y	N	Myocardial Infarction (Heart Attack)	Y	N
Diabetes	Y	N	Stomach Ulcers	Y	N
High Blood Pressure	Y	N	Stroke	Y	N

Other Medical Problems (Specify)_____

Past Surgical History: Have you ever had surgery for - Circle Yes or No

Appendix	Y	N	Hernia	Y	N
Back / Spine	Y	N	Hysterectomy	Y	N
C-Section	Y	N	Sinus	Y	N
Gall Bladder	Y	N	Tonsils	Y	N

Other Surgeries (Specify)_____

Family History: Has anyone in your immediate family (Mom/Dad/Brothers/Sisters) suffered from:

Cancer	Y	N	Type:_____
Diabetes	Y	N	Type:_____
Heart Attacks	Y	N	At what age? _____
Strokes	Y	N	At what age? _____

Social Habits:

Do you smoke?	Y	N	_____ Daily _____ Weekly _____ Special Occasions
Do you drink alcohol?	Y	N	_____ Daily _____ Weekly _____ Special Occasions
Illegal drug use?	Y	N	_____ Daily _____ Weekly _____ Special Occasions

Allergies to Medicine? _____

Current Medications/Vitamins/Herbs? _____

Last Tetanus Shot? _____

Date of Last Menstrual Period? _____

PAIN QUESTIONS

Where is your PAIN?	Describe your PAIN	Duration of PAIN?

Circle the number that describes your level of pain (0 = NO PAIN . . . .10 = WORST PAIN)

0 1 2 3 4 5 6 7 8 9 10



Reviewed by:

Patient Signature_____ Date:_____ Dr. Initial_____