SUPERIOR URGENT CARE
Excellence in Medical Service

PATIENT HISTORY QUESTIONNAIRE

List any allergies you have including medications, food or any other negative reaction and type of reaction.

❒ NKDA (No Known Drug Allergies)

Allergies: _____

List any medications you are currently taking, including over the counter medication. Please list medication strength and how often you take the medication:

Please Note: ***If you do not know the medication, please call your pharmacy. We are unable to provide care without a current medication list.***

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

PHARMACY INFORMATION

We may be able to send your prescription directly to your pharmacy. Please list the pharmacy where you want your prescription sent.

PHARMACY NAME	PHARMACY LOCATION

List all long term or recurring medical problems:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List any kind of surgery you have had: _____

_____

List any pertinent medical problems in your family and identify who (i.e. Mother, Father, Brother, Sister). Mark NONE if you have no family medical problems.

1. _____ FAMILY MEMBER / CONDITION
2. _____ FAMILY MEMBER / CONDITION
3. _____ FAMILY MEMBER / CONDITION
4. _____ FAMILY MEMBER / CONDITION

Do you smoke or use any tobacco products? ____YES _____NO _____I used to
___I smoke cigarettes ___cigars ___chew tobacco Quantity per day / week / month / year: _____

Do you use recreational drugs? ___YES ___NO ___I used to
Current Use: What type? _____ How often? _____

Do you drink alcohol? ___Never ____I used to ___I am in recovery
___I drink socially ___Regularly Quantity per day / week / month / year: _____

The following individuals are authorized to speak to Superior Urgent Care regarding my health information.

_____ Name / Relationship
_____ Name / Relationship
_____ Name / Relationship

My signature below acknowledges that I have been given a chance to review a copy of the Superior Urgent Care Notice of Privacy Practices.

PATIENT SIGNATURE: _____ *RELATIONSHIP IF OTHER THAN THE PATIENT:* _____

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