

Westlake Village Urgent Care HEALTH HISTORY FORM

Name: _____ Age _____ M / F Date: ___ / ___ / ___

WHY ARE YOU HERE TODAY? (Mark/ circle all that apply) or Other (Please explain): _____

PAIN: Chest Back Neck Abdomen Ribs Ear(s) Eye(s) Face Headache Bone Injury Other pain: _____
"Cold/ Flu" symptoms: Hard to Breathe Fever Chills Sore Throat Body Aches Runny nose Sinus congestion Cough Wheeze
GI/GU: diarrhea nausea vomiting constipation heartburn urinary pain/frequency (UTI) gynecological concern
Misc: palpitations swelling/edema dizziness numbness weakness fatigue anxiety depression insomnia
 vision change rash/skin problem allergic reaction _____
WELL VISIT: Physical (work/ sports) Labs/ Shots/ B-12 STD screening TB screening

Please list or attach all Medications including dose and how often you take them (Prescription and Over-the-Counter)

List Medication Allergies: _____ Environmental Allergies: (Latex, tape, pollen, etc) _____

YOUR PAST MEDICAL HISTORY (Check all that apply)

Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Eating Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy/Seizure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Head Injury/Concussion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmurs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Migraines	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Urinary Tract Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vision Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> No	List:					
Hospitalized	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain					

Recently travelled outside the US? No Yes: Where? _____ When? _____

SOCIAL HISTORY

Tobacco Use	<input type="checkbox"/> No	<input type="checkbox"/> Yes: Packs/Chew/Vaping per day? _____	Per Week? _____	How many years? _____
Alcohol Use	<input type="checkbox"/> No	<input type="checkbox"/> Yes: 1-5 per year _____	1-5 per week _____	1-2 per day _____
Drug Use	<input type="checkbox"/> No	<input type="checkbox"/> Yes: List: _____	Marijuana	<input type="checkbox"/> Yes <input type="checkbox"/> No
Exercise	<input type="checkbox"/> No	<input type="checkbox"/> Yes: How many days a week? _____		

FAMILY HISTORY (Mark all that apply for blood relatives ie: parents ,grandparents, siblings)

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cancer
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Migraines	<input type="checkbox"/> Depression	<input type="checkbox"/>

FEMALE HISTORY

Are you Pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last menstrual period? ___/___/___	Birth control used?
Date of last Pap smear:	Do you have a history of abnormal Pap smears?		Date:	

CHILDREN'S HISTORY

Are immunizations up to date?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Normal development?	<input type="checkbox"/> Yes	<input type="checkbox"/> No Explain:
Does anyone in the home smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Animals in the house?	<input type="checkbox"/> Yes	(Circle) Dog, Cat, Bird, Rodents, Reptiles

SIGNATURE: _____ DATE: _____