AFC URGENT CARE RALEIGH MIDTOWN

NEW PATIENT MEDICAL HISTORY FORM

NAME: _____ DATE OF BIRTH: _____

ALLERGIES (Drugs & Other)

o **NO KNOWN DRUG ALLERGIES**

MEDICATION OR OTHER NAME	**REACTION**

MEDICATIONS

MEDICATIONS *(Please list ALL)*	**DOSE** STRENGTH	**HOW TAKEN &** HOW MANY TIMES PER DAY

***If you need more room to list medications, please write them on a blank sheet of paper with the required information. ***

PHARMACY LOCAL & MAIL ORDER (IF USED)	**PHONE NUMBER &** FAX NUMBER	**LOCATION** ADDRESS

2913 Wake Forst Rd. Raleigh, NC 27609 Ph: 919-899-4000 Fax: 984-200-5343

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OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME & PHONE #	DATE OF LAST VISIT
Current Primary Care Provider		

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM/BREAST EXAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY	Date:	Facility/Provider:	Abnormal Result? Y N
PSA/PROSTATE EXAM	Date:	Facility/Provider:	Abnormal Results? Y N

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			

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PERSONAL MEDICAL HISTORY CONTINUED			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Stroke			
Other:			
Other:			

SURGERIES

TYPE *(specify left/right)*	**DATE**	**LOCATION/FACILITY**

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WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle: _____	Age of First Menstruation: _____ Age of Menopause: _____
Total Number of Pregnancies: _____	Number of Live Births: _____ Still Born: _____
# of Vaginal Births: _____ C-Sections: _____	Miscarriages: _____

FAMILY MEDICAL HISTORY

o **NO SIGNIFICANT FAMILY HISTORY IS KNOWN**

4 **ChECK ALL ThAT APPLY**	Alcohol/DrugAbuse)	Asthma	Cancer *type:*_____	Emphysema(COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	EarlyDeath	HeartDisease	HighCholesterol	HighBloodPressure	KidneyDisease	Stroke	ThyroidDisease	Migraines	Other:_____	Other:_____	Other:_____
Mother																		
Father					(													
Brother																		
Sister																		
Child																		
MGM																		
MGF																		
PGM																		
PGF																		
Other:_____																		

SOCIAL HISTORY

Occupation *(or prior occupation)*:	o Retired o Unemployed o LOA o Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: o Single o Partner o Married o Divorced o Widowed o Other:_____	
Do you have children? Y N	If yes, how many?

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VACCINE HISTORY

TYPE *(specify left/right)*	**DATE**
TETANUS	
DIPTHERIA	
PNEUMOCOCCAL	
SHINGLES	
INFLUENZA	
COVID 19	
OTHER/IF MINOR, PLEASE BRING VACCINE/IMMUNIZATION RECORDS	

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day _____ # of Years _____	***Past:*** Quit Date: _____ Packs/day _____ # of Years _____		
Other Tobacco *(check one)*: o Pipe o Cigar o Snuff o Chew			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	o Beer o Wine o Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: o Male o Female		
Birth control method: o None o Condom o Pill/Ring/Patch/Inj/IUD o Vasectomy		
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.): _____ How often: _____	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working night shift)*?	

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DIET	How would you rate your diet? o Good o Fair o Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? Y N

ADDITIONAL INFORMATION

Have you traveled outside of the country in the last 30 days? Y N	If yes, where?
Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?