

**Alaska Urgent Care**  
**MEDICAL HISTORY FORM**

**Patient Information**

Patient Name \_\_\_\_\_ Sex:  F  M DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Care Physician \_\_\_\_\_

Allergies \_\_\_\_\_

Current Medications (including herbs, supplements, over-the-counter meds) \_\_\_\_\_

Medical History (list all past/current medical conditions) \_\_\_\_\_

Surgical History (list all surgeries) \_\_\_\_\_

**Social History**

Smoker  No  Yes \_\_\_\_\_ pack/day for years  Quit: if so, when: \_\_\_\_\_

Alcohol  Never  Rarely  Occasional  Moderate  Excessive  Quit: if so, when: \_\_\_\_\_

Recreational Drugs  No  Yes  Quit: if so, when: \_\_\_\_\_

Traveled Abroad:  No  Yes Location: \_\_\_\_\_ Year: \_\_\_\_\_

**Family History**

Mother:  Deceased  Diabetes  Cancer  Hypertension  Coronary Heart Disease  Other

Father:  Deceased  Diabetes  Cancer  Hypertension  Coronary Heart Disease  Other

Sibling(s):  Deceased  Diabetes  Cancer  Hypertension  Coronary Heart Disease  Other

Notes: \_\_\_\_\_

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