



North Smithfield

Urgent Care

MEDICAL QUESTIONNAIRE

Patients Name: _____ Date: _____

Reason for today's Visit: _____

Did your symptoms begin within the last 24 hours ____ Yes ____ No

Have you been treated for these symptoms previously ____ Yes ____ No

Is this visit due to an Accident/Injury: ____ Yes ____ No Type of Accident/Injury: ____ Work ____ Auto ____ Other

Social History: Smoker ____ Yes ____ No Packs per day: _____

Alcohol ____ Yes ____ No If yes how often do you drink: ____ daily ____ weekly ____ socially

History of/or current recreational drug use? ____ Yes ____ No

Please list any medication allergies: _____

Are you allergic to any of the following: _____ Latex _____ Eggs

Please List All Medications/Vitamins/Supplements: _____

X PATIENT SIGNATURE: _____ Date: ____/____/____

MEDICAL HISTORY

Patients Medical History: Please circle all that apply.

Anemia	Arthritis	Asthma	Atrial Fibrillation
Blood Clots-DVT	Cancer (type)	COPD	Concussion
Crohn's disease	Depression/Anxiety	Diverticulitis	Diabetes: type I or II
Emphysema	Gout	Heart Disease	Hepatitis: A B or C
High blood pressure	High Cholesterol	HIV or AIDS	Irritable Bowel syndrome
Kidney disease	Multiple sclerosis	Osteoporosis	Parkinson's
Rheumatoid Arthritis	Stroke	Thyroid disease	Other

Please List Major Surgeries: _____

X PATIENT SIGNATURE: _____ Date: ____/____/____