St. Michael's Urgent Care of Hattiesburg

Name: _____ Birthdate: ____ /____/_____ Today's Date: ____ /____/_____

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. ☐ TAKE NO MEDICATIONS

Medication Name	Dose	Frequency (how often per day)	Reason for taking

ALLERGIES AND/OR MEDICATION INTOLERANCES: ☐ NONE

Medication Name	Specific type of reaction	Severity (circle one)
		Mild
		Mild

MEDICAL HISTORY: Please list any current or past medical conditions for which you have been treated. ☐ NONE

SURGICAL HISTORY: Please list any procedure or surgeries. ☐ NONE

Surgery Type	Date	Comments

SOCIAL HISTORY:

Tobacco Use: ☐ NONE (Skip to Alcohol Use)

Smoke cigarettes: ☐ Never ☐ No ☐ Yes Current smoker: Packs/day: _____ # of years: _____

Quit date: _____ How many years did you smoke? _____

Approximately how many packs a day did you smoke? _____ Other tobacco: _____

Alcohol ☐ yes ☐ no ____ how much _____

Caffeine ☐ yes ☐ no ____ how much _____

Drugs Do you use marijuana or recreational drugs? _____

Have you ever used needles to inject drugs? _____

Exercise: Do you exercise regularly? ☐ Yes ☐ No What kind of exercise? _____

How long (minutes)? _____ How often? (# of days per week) _____

FAMILY MEDICAL HISTORY: Please list any current or past medical conditions for which YOUR PARENTS or GRANDPARENTS have been treated.

Submit Reset Form