WellStar Urgent Care
HEALTH HISTORY

Date: _____ Name: _____ Date of Birth: _____

1 Please list all medication allergies: _____

_____

Are you allergic to latex: ❑ Yes ❑ No

2 Please list all medications you take regularly. _____

_____

3 Is there anything we need to know about
your religion or culture in order to care for you? ❑ Yes ❑ No
Do you have any barriers to learning? ❑ Yes ❑ No
Do you have an Advanced Directive (living will): ❑ Yes ❑ No

How do you best learn?
❑ Verbal ❑ Written
❑ Demonstration

4 Please mark with an "X" all of the following that you have now or have ever had:

____ 1 Abnormal chest x-ray
____ 2 Alcohol/substance abuse
Type and amount: _____
____ 3 Anemia
____ 4 Arthritis
____ 5 Asthma
____ 6 Back pain or injury
____ 7 Cancer
____ 8 Cerebral palsy
____ 9 Chest pain (angina)
____ 10 Chronic headaches
____ 11 Diabetes
____ 12 Dizziness or fainting
____ 13 Ear or hearing problems
____ 14 Emphysema or lung disease
____ 15 Epilepsy
____ 16 Eye problems
____ 17 Female: Gynecologic problems
____ 18 Fractures
____ 19 Hay fever
____ 20 Head injury
____ 21 Heart disease
____ 22 Hemophilia
____ 23 Hernia
____ 24 High blood pressure
____ 25 High cholesterol
____ 26 Hypoglycemia
____ 27 Kidney/bladder problems
____ 28 Knee injury
____ 29 Male: Prostate/genital problems
____ 30 Mental or nervous disorder
____ 31 Muscle disease
____ 32 Parkinson's disease
____ 33 Rheumatic fever
____ 34 Sexually Transmitted Disease
____ 35 Shortness of breath
____ 36 Sickle cell anemia
____ 37 Skin conditions
____ 38 Stomach ulcers
____ 39 Stroke
____ 40 Surgery
____ 41 Swollen ankles
____ 42 Thyroid problems
43 Tobacco use
Type and amount: _____
____ 44 Tuberculosis
____ 45 Varicose veins
____ 46 Other _____

Please explain all "Yes" answers below (identify by number):

Number	Date	Explanation

5 Have you had a serious illness, health problem, surgery, or injury not listed above, please list below:

If yes, please describe: _____

_____

_____
Reviewing Provider / Date Reviewed

Acknowledgement of Receipt of "NOTICE OF PRIVACY PRACTICES" for Protected Health Information

I, acknowledge that I have received a copy of WellStar Health System's "*Notice of Privacy Practices*" for Protected Health Information on the date set forth below.

_____
Patient Signature or Authorized Personal Rep.

_____ _____
Relationship to Patient Date

PLACE PATIENT LABEL HERE