OnPoint Urgent Care

ONPOINT HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are **strictly confidential** and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	DOB:	Today's Date:
If Under 18: List Parents/Guardian(s):		
Marital status of Patient: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Primary Care Provider's Name & phone/fax # (if available):		

PERSONAL HEALTH HISTORY

Immunizations: ☐ Tetanus: Year_____ Tdap or Td? _____ ☐ Influenza: Year _____ ☐ Pneumonia: Year_____

List all past medical problems such as high blood pressure, diabetes, bronchitis, sleep apnea, etc.

☐ NONE			

List surgeries such as gallbladder removal, appendectomy, heart surgeries, back surgeries, etc. and the year of the surgery

☐ NONE			

List all medications currently being used including prescribed, OTC meds, supplements and oxygen

Name of Medication/Reason for Medication	Strength	How Often?	Name of Medication/Reason for Medication	Strength	How Often?
☐ NONE					

Allergies to *Medications*, *Foods* and/or *Environment*

Name of Medication/Allergen	Reaction You Had	Name of Medication/Allergen	Reaction You Had
☐ NONE			

FAMILY HEALTH HISTORY

☐ ADOPTED	SIGNIFICANT HEALTH PROBLEMS				SIGNIFICANT HEALTH PROBLEMS	
Father			☐ NONE	**Children**	☐ M ☐ F	☐ NONE
Age:					☐ M ☐ F	☐ NONE
Mother			☐ NONE		☐ M ☐ F	☐ NONE
Age:					☐ M ☐ F	☐ NONE
Siblings ☐ M ☐ F	**Age:**			☐ NONE	**Grandmother** *Maternal*	☐ NONE
☐ M ☐ F	**Age:**			☐ NONE	**Grandfather** *Maternal*	☐ NONE

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	☐ M ☐ F	**Age:**			☐ NONE	**Grandmother** *Paternal*		☐ NONE
	☐ M ☐ F	**Age:**			☐ NONE	**Grandfather** *Paternal*		☐ NONE

ALMOST FINISHED!! PLEASE COMPLETE THE FOLLOWING SOCIAL HISTORY

Exercise: How many times do you usually exercise each week?	
What type of exercise do you normally do and for how long?	

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	☐ None	☐ Daily	☐ Socially (Weekends)	☐ Rarely (Special Occasions)
	What kind of Alcohol do you prefer?	Beer, Wine, Hard Liquor		
Tobacco	Do you use tobacco?	☐ Yes	☐ No	
	☐ Cigarettes: # of packs per day:_____	☐ Chew: #/day_____	☐ Pipe: #/day_____	☐ Cigars: #/day_____
	☐ # of years:_____	☐ I Quit!! Year Quit:_____ Previous # of Packs per Day:_____ How many years smoked:_____		

Drugs	Do you currently use recreational drugs?	☐ Yes	☐ No	Which One(s)?