Wise Family Practice
Urgent Care

Medical Record Update

PATIENT NAME____________________________________ **DATE OF BIRTH:** __________

SOCIAL HISTORY (Please check all that apply):

Race	□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White □ Decline to answer
Ethnicity	□ Hispanic or Latino □ Not Hispanic or Latino □ Decline to answer
Preferred Language	□ English □ Spanish □ Other:
Occupation	
Smoking Status	□ Current Every Day Smoker □ Current Some Day Smoker □ Former Smoker □ Never Smoker
Smokeless Tobacco User	□ Yes □ No
Alcohol Use	□ Yes □ No □ Present □ Past
Drug Use	□ Yes □ No □ Present □ Past
Sexually Active	□ Yes □ No If Yes: □ Monogamous □ Multiple Partners

PERSONAL MEDICAL HISTORY (Please check all that apply):

□ Diabetes	□ Depression / Anxiety	□ "Hay Fever"	□ Gout
□ Hypertension	□ GERD / Reflux	□ Osteoporosis	□ Alcoholism
□ Hyperlipidemia	□ Heart Disease	□ Hepatitis	□ Stroke
□ Heart Attack	□ Thyroid Disorder	□ Rheumatoid Arthritis	□ Cancer/Specify Type:__________

SURGICAL HISTORY (Please list all prior operations and dates):

Operation	Date/ Surgeon's Name

CURRENT MEDICATIONS		
Medication	**Dosage (Mg)**	**Times Per Day**

MEDICATION ALLERGIES	
Medication	**Reaction or Side Effect**

FAMILY MEDICAL HISTORY (Please check for all family members it applies):

Cancer	□Father	□Mother	□Brother	□Sister	□Daughter	□Son	□Mat. Grandmother	□ Mat. Grandfather	□ Pat. Grandmother	□Pat. Grandfather
Stroke	□Father	□Mother	□Brother	□Sister	□Daughter	□Son	□Mat. Grandmother	□ Mat. Grandfather	□ Pat. Grandmother	□Pat. Grandfather
Diabetes	□Father	□Mother	□Brother	□Sister	□Daughter	□Son	□Mat. Grandmother	□ Mat. Grandfather	□ Pat. Grandmother	□Pat. Grandfather
Hyperlipidemia	□Father	□Mother	□Brother	□Sister	□Daughter	□Son	□Mat. Grandmother	□ Mat. Grandfather	□ Pat. Grandmother	□Pat. Grandfather
Hypertension	□Father	□Mother	□Brother	□Sister	□Daughter	□Son	□Mat. Grandmother	□ Mat. Grandfather	□ Pat. Grandmother	□Pat. Grandfather
Kidney Disease	□Father	□Mother	□Brother	□Sister	□Daughter	□Son	□Mat. Grandmother	□ Mat. Grandfather	□ Pat. Grandmother	□Pat. Grandfather
Other_______	□Father	□Mother	□Brother	□Sister	□Daughter	□Son	□Mat. Grandmother	□ Mat. Grandfather	□ Pat. Grandmother	□Pat. Grandfather

Preferred Pharmacy: ______________________________ City:__________________ Phone #:_________________

By signing, you agree that we can request your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes. Signature: __________________________________