



2101 S. Loop 336 West, Suite 100 Conroe, Texas 77304

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FAMILY PASS MEDICAL HISTORY

Patient Name: _____ **DOB:** _____

Preferred Pharmacy: (Phone and Location)

Allergies: No known Allergies I am allergic to: _____ (Females) Are you pregnant? No Yes _____ weeks/months
Date of last menstrual cycle: _____

Current Medications: Please list all prescriptions, non-prescriptions, vitamins, supplements dosages and how often

Current and Past Medical History:
 Headaches High Blood Pressure Arthritis Bone/Joint Disease Prostate Disease Gastritis/Ulcer
 Depression/Anxiety Diabetes Asthma/COPD Chest Pain Heart Disease Hepatitis
 Gout HIV. Cancer (Type): _____
 Other: _____

Family History: (Check all that apply)
 Heart Disease Stroke Arthritis Osteoporosis Alzheimer’s Gout Mental Illness
 Cancer (Type): _____
 Other: _____

Have you had surgery in the past? No Yes If yes, Type/Date: _____

Do you smoke/chew tobacco? No Yes ___ Cigarettes ___ Packs/Day ___ Cigars ___ Per Day

Do you use drugs? No Yes (if yes, how often & what) _____

Do you drink alcoholic beverages? No Yes Beer Wine Liquor If Yes, how often? Socially Rarely Daily

Consent of Care:
I give permission to Family First Urgent Care, its physicians, affiliates, and medical personnel to provide medical services, including but not limited to x-rays, laboratory, administration of medications, anesthetics and any treatment recommended by the provider to me/child. I authorize Family First Urgent Care to disclose my current and previous medical records, consultation and treatment plans, to my referring physician, other healthcare providers, and hospitals that will participate in my care. I understand that by signing this form I am seeking medical care until I withdraw consent to Family First Urgent Care privacy officer in writing.

Signature

Date