Family First URGENT CARE
WE CARE FOR YOU LIKE FAMILY

2510 S. Loop 336 West, Suite 115 Conroe, Texas 77304
Tel: 936.235.2825 ♦ Fax: 936.235.2826

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. **I understand that certain* exclusions may apply. Specialty labs, COVID-19 testing, MRI, Ultrasounds are not included.

_____ _____

Signature **Date**