BROWARD OUTPATIENT URGENT CARE

150 S. Andrews Ave (Ext)
Suite #201
Pompano Beach, FL 33069

www.BrowardOutpatientUrgentCare.com
Phone: 1.888.646.2273
Fax: 1.888.745.7020

HEALTH HISTORY

Are you taking any of o the following medications?

☐ Nerve Pills ☐ Pain Killers (aspirins) ☐ Muscle Relaxers

☐ Stimulants ☐ Blood Thinners ☐ Tranquilizers

☐ Insulin ☐ Others _____

How much of each pill are you taking? _____

Have you ever had any of the following diseases /medical condition(s)?

☐ Heart Attack ☐ Heart Surgery / Pacemaker ☐ Heart Murmur

☐ Mitral Valve Prolapse ☐ Congenital Heart Defect ☐ Artificial Valves

☐ Stroke ☐ Alcohol / Drug Abuse ☐ Venereal Disease

☐ Hepatitis ☐ HIV / AIDS ☐ Shingles

☐ Cancer ☐ Frequent Neck Pain ☐ Emphysema / Glaucoma

☐ Anemia ☐ High / Low Blood Pressure ☐ Psychiatric Problems

☐ Rheumatic Fever ☐ Sever / Frequent Headaches ☐ Kidney Problems

☐ Ulcers/Colitis ☐ Fainting / Seizures / Epilepsy ☐ Sinus Problems

☐ Asthma ☐ Diabetes ☐ Tuberculosis

☐ Difficulty Breathing ☐ Chemotherapy ☐ Lower Back Problems

☐ Artificial Bones / Joints ☐ Arthritis ☐ Other _____

Do you smoke? ☐ Yes / ☐ No, If Yes, how much? How many years? _____

Are you wearing: ☐ Heels ☐ Sole Lifts ☐ Inner soles ☐ Arch Supports

What is the age of your mattress? Is it comfortable? ☐ Yes / ☐ No

WOMEN: Are you taking Birth Control? ☐ Yes / ☐ No Are you pregnant? ☐ Yes / ☐ No

List any other serious medical condition (s) you or have had: _____

List any other serious medical condition(s) you have or have had: _____

List any and all allergies: _____

List any and all previous surgeries / treatments (with dates): _____

List any past serious accidents (with dates & details): _____

Has anyone in your family suffered from any serious diseases / medical conditions? ☐ Yes / ☐ No

If yes, please explain: _____

Patient Name: _____ **Signature:** _____ **Date:** _____

Reviewed By: _____ **Signature:** _____ **Date:** _____