WakeMed Urgent Care Patient Intake Form

Patient Name_____ Date of Birth _____ Primary Doctor_____

Pharmacy for Today's Rx _____Reason for Visit_____

Past Medical History

Anxiety	❑ yes ❑ no	Diabetes	❑ yes ❑ no	Osteoporosis	❑ yes ❑ no
Asthma	❑ yes ❑ no	High Cholesterol	❑ yes ❑ no	Seasonal Allergies	❑ yes ❑ no
ADD/ADHD	❑ yes ❑ no	Hypertension	❑ yes ❑ no	Stroke	❑ yes ❑ no
Cancer	❑ yes ❑ no	Kidney Stones	❑ yes ❑ no	Thyroid Disease	❑ yes ❑ no
COPD	❑ yes ❑ no	Heart Attack	❑ yes ❑ no		
Depression	❑ yes ❑ no				

Other:_____ Type:_____

Past Surgical History

Appendectomy	❑ yes ❑ no	Tubes in Ears	❑ yes ❑ no	Tubal Ligation	❑ yes ❑ no
Gallbladder Removal	❑ yes ❑ no	Tonsillectomy	❑ yes ❑ no	C-Section	❑ yes ❑ no
Hernia Repair	❑ yes ❑ no	Partial Hysterectomy	❑ yes ❑ no	Other: _____	
Vasectomy	❑ yes ❑ no	Complete Hysterectomy	❑ yes ❑ no		

Family History

	Asthma	Diabetes	Heart Disease	High Cholesterol	High Blood Pressure	Irritable Bowel Disease	Cancer Type	Cancer Type	Cancer Type	Other Type
Mother										
Father										
Sister										
Brother										
Daughter										
Son										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										

Adopted ❑ yes ❑ no Family History ❑ Known ❑ Unknown

Social History

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Tobacco Use

❑ yes ❑ never ❑quit date: ____

Packs/Day_____

Years Smoked _____

Smokeless Tobacco Use

Living with smoker _____

Alcohol

❑ no ❑ social ❑ frequently

Wine (# of servings)_____

Beer(# of servings)_____

Liquor (# of servings)_____

Drug Use

❑ yes ❑ never ❑ quit

Type of Drug _____

Currently in School ❑ yes ❑ no Living with parents ❑ yes ❑ no

Child Enrolled in Daycare ❑ yes ❑ no

Drug Allergies/Reaction/Date:

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Current Medications/Reason for taking/Dosage Times per day

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Immunizations

Childhood Immunizations up to date? ❑ yes ❑ no

Circle One

TDap/Tetanus ❑ yes ❑ no Within the past **5 yrs?** ❑ yes ❑ no

Flu Shot ❑ yes ❑ no Month & Year: _____