URBANCARE
INTERNAL MEDICINE & PEDIATRICS

Date of Visit ___/___/___ **Date of Birth** ___/___/___ **Age** ___

Patient Name _____

Physician Information: Please provide the names and contact information (office address, phone, fax, specialty and/or hospital information) for all the doctors involved in your care.		
Physician Name **Address / Hospital Affiliation**	**Phone**	**Fax**

Current Medications:	**Dose:**	**Frequency:**

Past Medical History: **(Please check all that apply)**	**Yes**	**No**	**Describe**
Cancer	☐	☐	
Cardiovascular			
High blood pressure	☐	☐	
High cholesterol	☐	☐	
Arrhythmia	☐	☐	
Heart Attack (MI)	☐	☐	Date (year):
Congestive heart failure	☐	☐	
Stroke/TIA	☐	☐	Date (year):
Blood clots	☐	☐	
Bleeding disorder	☐	☐	
Respiratory			
Emphysema / COPD	☐	☐	
Asthma	☐	☐	
Endocrine			
Thyroid Disease	☐	☐	
Diabetes	☐	☐	

Past Medical History (continued): (Please check all that apply)	Yes	No	Describe
Gastrointestinal			
Reflux	☐	☐	
Stomach ulcer	☐	☐	
Liver disease/cirrhosis/hepatitis	☐	☐	
Irritable Bowel /Chron's / Colitis	☐	☐	
Polyps	☐	☐	
Genitourinary			
Kidney / bladder problems	☐	☐	
Gynecological problems	☐	☐	
Prostate problems / BPH	☐	☐	
Sexual dysfunction	☐	☐	
Musculoskeletal			
Arthritis	☐	☐	
Osteoporosis	☐	☐	
Autoimmune			
Rheumatoid Arthritis	☐	☐	
HIV / AIDS	☐	☐	
Neurologic			
Epilepsy / Seizure disorder	☐	☐	
Parkinson's	☐	☐	
Alzheimer's	☐	☐	
Psychiatric			
Depression / Anxiety	☐	☐	
Bipolar / Schizophrenia / Panic Disorder	☐	☐	
Other			
Other diseases?	☐	☐	

History of surgery or other procedures		☐ **No prior surgeries or procedures**
Type of Surgery / Procedure	**Date**	**Hospital / Clinic where performed**
Do you have an Internal Electronic Device (i.e. defibrillator / pacemaker)?	☐ **Yes**	☐ **No**

Health Maintenance		
	☐ Yes, Date _____	☐ No

	☐ Yes, Date _____	☐ No
	☐ Yes, Date _____	☐ No
	☐ Yes, Date _____	☐ No

Allergies: Include medications / food / environmental	☐ **No known allergies**
Allergy	**Describe reaction**

Social History
Whom do you live with?
Do you have children? Yes ☐ No ☐ List ages:
Do you drink alcohol? Yes ☐ No ☐ Number of drinks per week: If you used to drink, when did you stop?
Do you use tobacco products now or in the past (cigars, cigarettes, tobacco)? Yes ☐ No ☐ Do you use E-cigarettes? Yes ☐ No ☐ Number of years: _____ Number of packs per day: _____ When did you quit? _____ Are you interested in information regarding smoking cessation? Yes ☐ No ☐
Do you use recreational drugs? Yes ☐ No ☐ If yes, what drug(s)? How often?
Do you have special religious, spiritual, or cultural needs that we should be aware of? Yes ☐ No ☐ If yes, please explain:
Do you have Advanced Directives (living will, power of attorney for health care)? Yes ☐ No ☐ If yes, could you provide a copy for your records? Yes ☐ No ☐

Family History (please check all that apply)	**Mother**	**Father**	**Sibling** ☐Brother ☐Sister	**Sibling** ☐Brother ☐Sister	**Sibling** ☐Brother ☐Sister	**Sibling** ☐Brother ☐Sister	**Other**
Diabetes	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐	☐	☐
Other Cancer _____	☐	☐	☐	☐	☐	☐	☐
Status							
Alive	☐	☐	☐	☐	☐	☐	☐
Deceased	☐	☐	☐	☐	☐	☐	☐
Age of Death							
Age of Diagnosis							
☐ Adopted			☐No significant family				