Alaska Urgent Care
300 E Dimond Blvd, #12A
Anchorage, AK 99515
907-341-7757

Medical History

Patient Information

Patient Name: _____ Sex: □ M □ F DOB: ___/___/_____
Primary Care Physician: _____
Allergies: _____
Current Medications and/or Supplements/Vitamins: _____
_____
Medical History (list all past and current medical conditions):
_____
_____
Surgical History (list all surgeries): _____
_____

Social History

Tobacco Use: □ No □ Yes, _____ packs/day for _____ years □ Quit: if so, when? _____

Alcohol Use: □ Never □ Occasional □ Daily □ Quit: if so, when? _____

Recreational Drug Use: □ No □Yes □ Quit: if so, when? _____

Do you live with someone who uses recreational drugs? □ No □ Yes

Traveled Abroad? □ No □ Yes: if so, location: _____ Year: _____

Family History

Mother: □ Deceased □ Diabetes □ Cancer □ Hypertension □ Coronary Heart Disease □ Other

Father: □ Deceased □ Diabetes □ Cancer □ Hypertension □ Coronary Heart Disease □ Other

Sibling(s): □ Deceased □ Diabetes □ Cancer □ Hypertension □ Coronary Heart Disease □ Other

Notes:_____
_____
_____
_____

Preferred Pharmacy: _____