



# North Georgia Urgent Care

www.mynguc.com

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Current Address: \_\_\_\_\_

CITY/STATE/ZIP

Phone Number: \_\_\_\_\_

Main Complaint/Reason for Visit:

What is the reason for your visit? \_\_\_\_\_

When did this happen or first start? \_\_\_\_\_

\*\*\*If this occurred at work, please advise the front desk\*\*\*

Past Medical History- (Circle)					
High Blood Pressure	Yes	No	Liver Disease	Yes	No
Heart Attack	Yes	No	Kidney Disease	Yes	No
Diabetes	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Stomach Ulcers	Yes	No
Other Medical Problems:					

Past Surgical History- (Circle)					
Hysterectomy	Yes	No	Back or Spine	Yes	No
Gall Bladder	Yes	No	Tonsils	Yes	No
Appendix	Yes	No	Adenoids	Yes	No
Other Sugeries? Specify:					

Family History- Has anyone in your family (mom/dad/brothers/sisters) suffered from:				
Heart Attacks	Yes	No	At what age?	Who?
Strokes	Yes	No	At what age?	Who?
Cancer	Yes	No	At what age?	Who?
Social Habits				
Do you smoke?	Yes	No	How many packs per day?	
Do you drink alcohol?	Yes	No	How often do you drink?	

(Continued on back)

Any Allergies to medications \_\_\_\_\_

Current Medication and Dosage: \_\_\_\_\_

Vitamins or Herbal supplements: \_\_\_\_\_

Last Tetanus: \_\_\_\_\_

Date of Last Menstrual Period: \_\_\_\_\_

Pain Intensity Scale (Enter this number in the column)

0	1	2	3	4	5	6	7	8	9	10
No Pain										Worst Pain

Who referred you to our clinic today? \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_

What is the Name and Location of the Pharmacy you will be using today?  
\_\_\_\_\_