Surfside URGENT CARE OF LAGUNA BEACH

Patient Information Form

Please completely fill out this form to ensure the fastest and best healthcare service. Please print clearly.

Patient Name		Date of Birth	
Social Security #		Occupation	
Address			
City		State	ZIP
Mobile Phone		Home Phone	
Email		Work Phone	

Emergency Contacts

Name		Phone		Relationship	
Name		Phone		Relationship	

Primary Care Physician		Phone	
Pharmacy		Cross St.	Phone

How were you referred to our practice?

□ Drive by □ Internet □ Insurance □ Friend/Family □Other:

Primary reason for today's visit	
Medication Allergies	Reaction type
Current Medications	
Recent Travel?	
Alcohol Use □Yes □ No	Tobacco Use □ Yes □ No
Surgical History	Year Performed

Asthma	□ Yes □ No	Seizures	□ Yes □ No
Diabetes	□ Yes □ No	Heart Problems	□ Yes □ No
COPD	□ Yes □ No	Migraines	□ Yes □ No
Cancer	□ Yes □ No	Thyroid Disease	□ Yes □ No
Enlarged Prostate	□ Yes □ No	Pregnant	□ Yes □ No
Elevated Cholesterol	□ Yes □ No		If yes:_____weeks
High Blood Pressure	□ Yes □ No	Other:_____	If no LMP: _____