LMG LOUDOUN MEDICAL GROUP
CORNWALL URGENT CARE

Cornwall Urgent Care Patient Medical History

Patient Name: _____ Date of Birth: _____

Email Address: _____

Primary Care Doctor: _____ Referring Doctor: _____

Reason for Visit:_____

Preferred Pharmacy: _____

Allergies:_____

Medications: (List all medications, including vitamins and supplements)

Medication Name & Dose	Date Started	Prescribed by

Past Medical History (Please circle all that apply)

Anxiety	Diabetes Mellitus	Glaucoma	Lupus
Anemia	Depression	Headaches	Lyme Disease
Asthma	Dizziness/Vertigo	Herpes	Osteoporosis
Alcohol Disorder	Easy Bleeding	HIV Infection	Rheumatoid Arthritis
Bronchitis	Emphysema	Heart Disease	Seizure Disorder
Back Problems	Esophageal Reflux	High Blood Pressure	Sleep Apnea
Cancer	Fatigue	Hodgkins Disease	Thyroid Disorder
Concussion	Gastrointestinal Disorder	Insomnia	Stroke Syndrome
High Cholesterol			

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Patient Name:_____ DOB:_____

Past Surgical History (Please check all that apply and include the date)

Surgery	Date	Surgery	Date	Surgery	Date
Appendectomy		Hernia Repair		Shoulder Surgery	
Back Surgery		Hysterectomy		Sinus Surgery	
Breast Surgery		Hip Surgery		Tonsillectomy	
Cataract Surgery		Knee Surgery		Thyroid Surgery	
C-Section		Laparoscopy		Vasectomy	
Colonoscopy		Pacemaker		Wisdom Teeth	
Cosmetic Surgery		Prostate Surgery		Other:	

Date of Last Tetanus Shot: _____

Gynecological History (For Females Only)

Last Menstrual Period:_____ # Of Pregnancies: _____ # of births:_____

Date of Last Pap: _____ Current Method of Birth Control: _____

Date of Last Mammogram:_____