Urgent Care Center

Patient Name: _____ **DOB:** _____ **Phone:** _____

What Pharmacy would you like to use today for your medicine? _____

What is the main reason that you are here? _____ **How long has it been going on?** _____

Work Related? _____ **If so, name of employer:** _____

If you are here for an injury, please answer the following: Date of Injury: _____

How did it happen? _____

IF YOU ARE HAVING CHEST PAIN OR PRESSURE, TELL ONE OF THE EMPLOYEES UP FRONT NOW!

Please answer every question with either yes ("Y") or no ("N") according to symptoms you have had in the past 2 days.

CONSTITUTIONAL

Y N Change in appetite
Y N Fever
Y N Chills
Y N Night Sweats
Y N Weight Loss
Y N Fatigue

EENT

Y N Eye Irritation
Y N Vision Changes
Y N Eye Pain
Y N Red Eyes
Y N Eyes Watering/ Discharge
Y N Difficulty Hearing
Y N Ear Pain
Y N Frequent Nosebleeds
Y N Nose Problems
Y N Sinus Problems
Y N Sore Throat
Y N Mouth Ulcers
Y N Teeth Problems

CARDIOVASCULAR

Y N Chest Pain when Resting
Y N Chest Pain when exercising
Y N Arm Pain when exercising
Y N Short of breath exercising
Y N Short of breath at rest
Y N Palpitations/Fluttering

RESPIRATORY

Y N Cough
Y N Wheezing
Y N Short of Breath
Y N Chest Congestion

GASTROINTESTINAL

Y N Abdominal Pain
Y N Nausea
Y N Vomiting
Y N Constipation
Y N Black or Tarry Stools
Y N Frequent Diarrhea
Y N Vomiting Blood

URINARY

Y N Difficulty Urinating
Y N Urinating more Frequently
Y N Blood in Urine
Y N Pain During Urination
Y N Penile Discharge
Y N Vaginal Discharge

MUSCULOSKELETAL

Y N Muscle Aches
Y N Joint Pain
Y N Back Pain

SKIN

Y N Abnormal Mole
Y N Rash
Y N Growth/lesion
Y N Laceration

NERVOUS SYSTEM

Y N Fainting/"Knocked Out"
Y N Weakness
Y N Numbness
Y N Seizures
Y N Dizziness
Y N Headache

PHYCHIATRIC

Y N Depression
Y N Sleep Disturbance
Y N Restless Sleep
Y N Anxiety
Y N Hallucinations
Y N Suicidal

ENDOCRINE

Y N Increased Thirst
Y N Temperature Intolerance
Y N Swollen Glands

HEMATOLOGY

Y N Easy Bruising
Y N Excessive Bleeding

ALLERGY

Y N Runny Nose
Y N Sinus Pressure
Y N Itching
Y N Hives

Name of Primary Care

Name of Specialist:

We are Christians and we pray for all of our patients every day, but if you would like for someone to pray for you individually today, we would be very happy to do so. Please check here: _____YES

_____ _____

Signature of Patient or Legal Representative: **Date:**

How did you hear about us? ___Newspaper Ad ___Internet ___ Friend ____Other _____

For Office Use Only

Room # _____