Urgent Care Center

Patient Name: ______________________________ DOB: __________ Phone: __________________

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 # ________