Today's Date: _____

Patient Name: _____

Date of Birth: _____ SS #: XXX - XX - _____

Tchefuncta urgent care

What is the reason for your visit today? _____

T _____ P _____ R _____ BP _____ O2 _____ LMP _____ Tet UTD _____ WT _____

Is this condition related to a ***Work Related Accident?*** [ ] Yes [ ] No Date of Accident: ____/____/____

Please read all information carefully. All of your paperwork must be filled out completely and correctly.

Please tell us if you are having any problems* TODAY *with the following:

Constitution		
Y	N	Chills
Y	N	Fatigue
Y	N	Fever
Y	N	Recent Weight Loss

Eyes		
Y	N	Eye Itching
Y	N	Eye Matting / Discharge
Y	N	Eye Pain
Y	N	Eyelid Redness
Y	N	Vision Changes

ENT / Mouth		
Y	N	Ear Drainage
Y	N	Ear Pain / Pressure
Y	N	Hearing Loss
Y	N	Hoarseness
Y	N	Popping of Ears
Y	N	Post-nasal Drip
Y	N	Sinus Pressure / Drainage
Y	N	Sore Throat
Y	N	Stuffy Nose
Y	N	Tinnitus (Ear Ringing)
Y	N	Toothache

Cardio		
Y	N	Chest Pain / Pressure
Y	N	DOE (Short of breath w/exertion)
Y	N	PND (Wake up short of breath at night)
Y	N	Palpitations

Respiratory		
Y	N	Cough
Y	N	Coughing Blood / Hemoptysis
Y	N	Shortness of Breath
Y	N	Wheezing

GI		
Y	N	Abdominal Pain
Y	N	Bloating
Y	N	Constipation
Y	N	Diarrhea

GI Cont.		
Y	N	Gas / Indigestion
Y	N	Nausea
Y	N	Rectal Bleeding
Y	N	Rectal Pain
Y	N	Vomiting

GU		
Y	N	Dysuria / Painful Urination
Y	N	Blood in Urine
Y	N	**History of Sexually Transm. Disease**
Y	N	Nocturia / > 2 x per night
Y	N	Penile Discharge
Y	N	Pregnancy
Y	N	Testicle Pain / Swelling
Y	N	Urinary Frequency
Y	N	Vaginal Discharge / Burning

Musc. / Skel.		
Y	N	Back Pain
Y	N	Fracture
Y	N	Joint Pain
Y	N	Muscle Spasm
Y	N	Muscle Aches / Myalgias
Y	N	Neck Pain
Y	N	Swelling in an Extremity

Skin / Breast		
Y	N	Abscess / Boil
Y	N	Bites / Sores
Y	N	Breast Lump
Y	N	Bruising / Ecchymosis
Y	N	Burn
Y	N	Color change
Y	N	Cut / Laceration

Skin / Breast Cont.		
Y	N	Itch
Y	N	Lesion
Y	N	Rash

Hema / Lymph		
Y	N	Bleeding
Y	N	Easy Bruising
Y	N	Painful / Swollen Lymph node

Allergy / Immunization		
Y	N	Allergies
Y	N	Hives
Y	N	Recurring Infections
Y	N	Hay Fever / Sneezing

Neurologic		
Y	N	Dizziness
Y	N	Fainting
Y	N	Headache
Y	N	Loss of Consciousness
Y	N	Memory Loss
Y	N	Muscle Weakness
Y	N	Numbness / Tingling
Y	N	Paralysis / Paresis
Y	N	Poor Balance
Y	N	Seizure
Y	N	Speech Difficulties

Psych		
Y	N	Anxiety
Y	N	Depression
Y	N	Insomnia (difficulty sleeping)

Patient Allergies: _____

Current Medications: _____

_____ _____

Signature of patient or Legal Representative **Date**