URGENT CARE AT HOME
powered by FAST TRACK

Last Name: ____ First Name: ____

Date of Birth: ____ Date of Visit: ____

I am having severe chest pain and shortness of breath, and I think I may be having a heart attack.	☐ Yes	☐ No
I am having numbness/weakness in my arms, legs or face, and I think I may be having a stroke.	☐ Yes	☐ No
I have recently lost consciousness or I am having extreme weakness, and I think I may pass out.	☐ Yes	☐ No
I am pregnant and I am having vaginal bleeding.	☐ Yes	☐ No

If you answered yes to any of the above questions or if you have a life-threatening medical concern, please notify staff immediately.

Medications:

☐ None

Please list all medications that the patient is currently taking: ____

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Please note: Our physicians will not write for, dispense or refill Schedule II or Schedule III drugs- including narcotics (such as hydrocodone, oxycodone, Percocet, Vicodin), benzodiazepines (such as Xanax, lorazepam), or amphetamines (such as Adderall, phentermine), written by other providers.

Past and Current Medical Conditions:

☐ None	☐ COPD/Emphysema	☐ High Blood Pressure	☐ Parkinson's Disease
☐ Acid Reflux / GERD	☐ Crohn's Disease	☐ High Cholesterol	☐ Peripheral Artery Disease
☐ Allergies	☐ Depression	☐ HIV/AIDS	☐ Prostate Cancer
☐ Alzheimer's Disease	☐ Diabetes	☐ Insomnia	☐ Rheumatoid Arthritis
☐ Anemia	☐ Eating Disorder	☐ Irritable Bowel (IBS)	☐ Seizures/Epilepsy
☐ Anxiety	☐ Enlarged Prostate	☐ Joint Injuries	☐ STD
☐ Arthritis	☐ Erectile Dysfunction	☐ Kidney Disease	☐ Skin Cancer
☐ Asthma	☐ Fibromyalgia	☐ Liver Disease	☐ Sleep Apnea
☐ ADHD	☐ Gallbladder Disease	☐ Low Back Pain	☐ Stroke
☐ Bleeding Disorders	☐ Gastrointestinal Ulcers	☐ Lung Cancer	☐ Thyroid Disease
☐ Breast Cancer	☐ Glaucoma	☐ Tuberculosis	☐ Vision Problems
☐ Broken or Fractured Bone(s)	☐ Gout	☐ Lupus	☐ Other / Not Listed
☐ Cataracts	☐ Hearing Problems	☐ Migraine	________________________
☐ Clotting Disorder	☐ Heart Attack	☐ Obesity	________________________
☐ Colon/Rectal Cancer	☐ Heart Disease	☐ Osteoporosis	________________________
☐ Congestive Heart Failure	☐ Hepatitis	☐ Overactive Bladder	________________________

Drug Allergies:

☐ None	☐ Depakote	☐ Morphine	☐ Other / Not Listed
☐ Amoxicillin	☐ Dilantin	☐ Other Antibiotics	________________________
☐ Anti-Seizure Medicine	☐ Erythromycin	☐ Other Pain Killers	________________________
☐ Aspirin	☐ Insulin	☐ Penicillin	________________________
☐ Codeine	☐ Iodine	☐ Sulfa	________________________
☐ Contrast Dye	☐ Latex		

Surgeries or Procedures:

☐ None	☐ Colon/Bowel Surgery	☐ Kidney Surgery	☐ Tonsillectomy
☐ Angioplasty	☐ Cosmetic Surgery	☐ Mastectomy	☐ Tubal Ligation
☐ Appendectomy	☐ Gallbladder Surgery	☐ Neurosurgery	☐ Vasectomy
☐ Back Surgery	☐ Gastric Bypass	☐ Orthopedic Surgery	☐ Other / Not Listed
☐ Breast Biopsy	☐ Heart Surgery	☐ Pacemaker Implantation	________________________
☐ Cardiac Stent / Catheterization	☐ Hernia Repair	☐ Prostate Surgery	________________________
☐ Cataract Surgery	☐ Hysterectomy	☐ Sinus Surgery	________________________
☐ Cesarean Section	☐ Joint Replacement	☐ Thyroid Surgery	________________________

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Last Name: ____ First Name: ____

Date of Birth: ____ Date of Visit: ____

Hospitalizations:

☐ None
☐ Alcoholism or Substance Abuse
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Congestive Heart Failure
☐ Depression
☐ Diabetes
☐ Heart Attack
☐ Heart Disease
☐ High Blood Pressure
☐ Injury
☐ Kidney Disease
☐ Liver Disease
☐ Pneumonia
☐ Stroke
☐ Seizures / Epilepsy
☐ Thyroid Disease
☐ Other / Not Listed
____
____
____
____

Family Medical History:

	Father	Mother	Grandfather	Grandmother	Siblings	Children
Acid Reflux / GERD	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Blood Disorder / Blood Clots	☐	☐	☐	☐	☐	☐
Cancer(s)	☐	☐	☐	☐	☐	☐
Depression / Anxiety	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐	☐	☐	☐
Heart Disease / Heart Attack	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Seizures or Epilepsy	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐

Other / Not Listed ____

Social History:

Are you a current smoker?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No
Do you drink caffeine?	☐ Yes	☐ No

Review of Systems: Please mark all recent symptoms associated with today's visit.

☐ None
☐ Fever
☐ Fatigue
☐ Weight Loss (unintentional)
☐ Weight Gain (unintentional)
☐ Headaches
☐ Loss of Vision
☐ Blurring of Vision
☐ Eye Pain
☐ Eye Irritation or redness
☐ Itchy Eyes
☐ Drainage from Eyes
☐ Earache
☐ Decreased Hearing
☐ Ringing of Ears
☐ Ear Discharge
☐ Sinus Pain or Pressure
☐ Nasal Congestion
☐ Runny Nose
☐ Nose Bleeds
☐ Sore Throat
☐ Loss of Voice
☐ Postnasal Drip
☐ Throat Swelling
☐ Dental Pain
☐ Neck Stiffness
☐ Swollen Neck Glands
☐ Chest Pain (Cardiac)
☐ Heart Palpitations
☐ Leg Swelling
☐ Cough
☐ Shortness of Breath
☐ Wheezing
☐ Coughing up Blood
☐ Loss of Appetite
☐ Painful Swallowing
☐ Abdominal Pain
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Dark Tarry Stools
☐ Blood in Stools
☐ Pain with Urination
☐ Frequent Urinations
☐ Strong Urge to Urinate
☐ Difficulty Urinating
☐ Blood in Urine
☐ Urine Output Changes
☐ Joint Pain
☐ Joint Swelling
☐ Muscle Aches
☐ Neck Pain
☐ Back Pain
☐ Loss of Consciousness
☐ Weakness or Paralysis
☐ Tingling or Numbness
☐ Dizziness
☐ Easy Bruising
☐ Easy Bleeding
☐ Leg Cramps
☐ Heat or Cold Intolerances
☐ Increased Thirst
☐ Rash
☐ Itchy Skin
☐ Dry Skin
☐ Lumps or Swelling
☐ Changes in Hair or Nails
☐ Depressed Mood
☐ Sleep Disturbances
☐ Other / Not Listed
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