URGENT CARE CENTER

Name: _____ Date of Birth: ___/___/___
Today's Date: _____
Reason for Visit: _____
Current Medications:

_____
_____
_____

Allergies: None / Yes
If yes, please list: _____
Medical History: (Circle if yes)
High Blood Pressure, High Cholesterol, Heart Disease, Diabetes, Asthma, Depression, Acid Reflux, Thyroid Disease, Cancer (if yes, which type) _____
Other: _____
Have you had the Corona Vaccine? Yes / No

Past Surgical History:

_____
_____

Family History:
High Blood Pressure, High Cholesterol, Heart Disease, Diabetes, Asthma, Depression, Acid Reflux, Thyroid Disease, Cancer (if yes, which type) _____
Other: _____

Occupation:
Alcohol:
Race:
Smoking:
Substance Abuse:

Do you have any symptoms?

	Fever		Flu-like symptoms		Headache
	Muscle Pain		Vomiting		Diarrhea
	Abdominal Pain		Unexplained Bleeding		None of the above

Within the last 30 days, have you traveled to/from out of state or out of the country? If so where?

_____

Have you been in contact with a person known or suspected of having the Corona virus? Yes / No

Patient/Guardian Signature: _____ Date: ___/___/___

Reviewed (MD Signature): _____