Room Number _____

EXPRESSMD URGENT CARE

Date:

DOB:

ID #:

Patient Name: _____ **INS / PP**

What is your primary complaint today?

_____

_____

_____

Past Medical History (please check any that apply): (Please circle N/A if none applies): **N/A**

☐ Diabetes	☐ Asthma	☐ ADD	☐ High Blood Pressure	☐ Thyroid
☐ Heart Disease	☐ Seizures	☐ ADHD	☐ Liver Disease	☐ Cholesterol
☐ Migraines	☐ Depression	☐ Gastric Reflux	☐ Kidney Failure	☐ Lung Disease
☐ Cancer	☐ Anxiety	☐ Ulcers	☐ Seasonal Allergies	☐ Back Problems

Other conditions: _____

Please list your medications (include dosage and frequency). If you have a list, please provide this list to the front desk so they can make a copy.

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Any Medication allergies? _____ Preferred Pharmacy? _____

Past Surgical History: (Please circle N/A if none applies): **N/A**

☐ Appendectomy	☐ Orthopedic Procedure	☐ Adenoidectomy	☐ Hernia
☐ Cholecystectomy	☐ Back Surgery	☐ Hysterectomy	☐ Neurosurgery
☐ Heart Surgery	☐ Tonsillectomy	☐ C-Section	☐ Other (list below)

Other surgeries: _____

Social History: Smoke? ☐ Yes ☐ No
If yes to smoke, how many cigarettes/days?

Alcohol? ☐ Yes ☐ No
If yes to alcohol, how often?

Illicit Drugs? ☐ Yes ☐ No
If yes to drugs, which ones?

Occupation: _____

Family History: Any family history of cancer, stroke, blood disorders, heart disease, or any other serious medical illnesses?

Mother: _____

Father: _____

Siblings: _____

FOR WOMEN ONLY:

In order to protect an unborn infant from receiving radiation, Express MD Urgent Care requests all women of childbearing age (approximately 12-55) to complete the following questions. If you have any reason to believe you might be pregnant, we need to know before you receive any test involving radiation. The information below that you provide us will remain confidential and will not be disclosed to anyone outside this clinic.
By filling out this portion, you are agreeing that you have read and understand the prior information and give your authorization for an x-ray or other nuclear procedure.

Are you pregnant? ☐ Yes ☐ No
Are you currently breastfeeding? ☐ Yes ☐ No
What was the start date of your last menstrual period? ___/___/___
Are you or your partner using any type of birth control? ☐ Yes ☐ NoHave you had a hysterectomy? ☐ Yes ☐ No

Primary Care Physician:
Name: _____ Location: _____
Phone Number: _____ Fax Number: _____

OFFICE/TECH USE ONLY

Vitals-BP / HR= T= O 2stat= % RR= WT(ILBS)= HT=