

First Choice Walk-In Care Information For Your Provider

PLEASE PRINT

Patient Last Name	Patient First Name	Middle Initial	Sex
Who is your personal physician?		REASON YOU NEED TO BE SEEN TODAY? (symptoms)	
Is this related to a work injury or motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No List all your medications: (include vitamins, injections, herbs, nasal sprays, oral sprays, patches, non-prescription drugs). List dosages if you know them. <input type="checkbox"/> Not taking any medications Medication: _____ Reason: _____ Medication: _____ Reason: _____ Medication: _____ Reason: _____ Medication: _____ Reason: _____ Medication: _____ Reason: _____			
What pharmacy would you like your prescription faxed to today? _____ <div style="text-align: right;">List pharmacy name, street and city</div>			
Are you allergic to any drugs? If so, list them and the reaction which occurred. _____ _____			
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you drink? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Check the appropriate surgeries you have had and what year they were performed: <input type="checkbox"/> Adenoids <input type="checkbox"/> Tonsils <input type="checkbox"/> Sinus <input type="checkbox"/> Eye <input type="checkbox"/> Heart/What type? _____ <input type="checkbox"/> Appendix <input type="checkbox"/> Colon <input type="checkbox"/> Uterus or Ovaries <input type="checkbox"/> Bladder <input type="checkbox"/> Tubal <input type="checkbox"/> Vasectomy <input type="checkbox"/> Other _____			
Do you have or ever had any of the following conditions? Please check all that apply.			
<input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Cholesterol <input type="checkbox"/> Chronic Pain/From? _____ <input type="checkbox"/> Thyroid <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> COPD or lung disease <input type="checkbox"/> Tuberculosis? <input type="checkbox"/> Reflux/Ulcer <input type="checkbox"/> Liver disease <input type="checkbox"/> Kidney disease <input type="checkbox"/> Cancer/What type? _____ <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> None listed above <input type="checkbox"/> Other _____			
Family History: Have your parents, grandparents, brothers or sisters been treated for any of the following? Check all that apply.			
<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Stroke <input type="checkbox"/> Cancer/What type? _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> None of the above			
List phone number we can call about visit & leave a voice message at: _____			
Is there a cell phone number you can be reached at? _____			Doctor Initials _____
PATIENT or GUARDIAN Signature _____		Date: _____	Time: _____
Relationship to Patient: _____			

OFFICE USE ONLY:

Consent to treat obtained from: Name: _____ Relation to patient: _____ PH: _____

Vitals: Wt: _____ T: _____ BP: _____ Pulse: _____ RR: _____ Pulse ox: _____ Vision: Rt 20/____ Lt 20/____

LMP: _____ Contraception: _____ Tob: Yes No ETOH: Yes No 04031611 NS (11/07)