TRUECARE URGENT CARE

CHIEF COMPLAINT

Patient's Name: _____ Today's Date: _____

Are you experiencing any of the following symptoms at this time? (check if yes and see the receptionist immediately)

_____ pressure or heaviness in the chest, pain in the chest radiating to the arms or jaw
_____ shortness of breath, difficulty breathing, wheezing, asthma attack
_____ sudden onset of one-sided weakness, numbness or tingling in face or extremities, speech difficulty, blurred vision, dizziness, headache, confusion
_____ fall or motor vehicle crash with neck pain, numbness or tingling in the extremities
_____ chemicals splashing in eyes
_____ foreign object in eye(s)
_____ medication overdose / chemical ingestion
_____ possible contagious rash or chickenpox

CHIEF COMPLAINT: Please tell us why you are here today. _____

_____

_____

Below is a list of Chief Complaints, please check each one of them that explains your reason for this visit.

HEAD

_____ Abscess
_____ Animal / Insect Bite
_____ Blurry Vision
_____ Dizziness
_____ Ear Ache
_____ Eye Problem
_____ Fever
_____ Headache
_____ Hives
_____ Laceration
_____ Pain in the Jaw/Teeth
_____ Rash
_____ Red Eyes
_____ Runny Nose
_____ Sneezing
_____ Sore Throat
_____ Suture Removal

ARMS, HANDS, LEGS, FEET

_____ Abscess
_____ Animal / Insect Bite
_____ Ankle Pain
_____ Arm Pain
_____ Elbow Pain
_____ Finger Pain
_____ Foot Pain
_____ Hand Pain
_____ Head Injury
_____ Head Trauma
_____ Hip Pain
_____ Hives
_____ Knee Pain
_____ Laceration
_____ Leg Pain
_____ Rash
_____ Shoulder Pain
_____ Suture Removal
_____ Toe Pain

NECK, BACK, CHEST, ABDOMEN

_____ Abdominal Pain
_____ Abscess
_____ Animal / Insect Bite
_____ Back Pain
_____ Blood in Stool
_____ Chest Pain
_____ Congestion
_____ Cough
_____ Diarrhea
_____ Difficulty Breathing
_____ Hives
_____ Laceration
_____ Nausea
_____ Neck Pain
_____ Rash
_____ Rectal Bleeding
_____ Respiratory Illness
_____ Rib Pain
_____ Shortness of Breath
_____ STD Exposure
_____ Suture Removal
_____ Vomiting
_____ Wheezing

List any other symptoms you are experiencing and how long: _____

_____

MEDICAL HISTORY QUESTIONAIRE

Do you have any medication allergies? ***Yes*** List: _____ ***No***

Is this visit related to a recent injury? **Yes** ***No*** Do you wear ***Glasses*** ***Contacts***

Are you currently Pregnant? ***Yes*** ***No*** Are you currently Breast Feeding? ***Yes*** ***No***

Last Menstrual Period started on _____ Are you currently on Birth Control Medication ***Yes*** ***No***

Have you been diagnosed with any of the following medical conditions, if not, please check "None of the Above":

_____ Abnormal Heart Rhythm
_____ Alcoholism
_____ Anxiety
_____ Arteriosclerosis
_____ Arthritis
_____ Asthma
_____ Blood Clots
_____ Bronchitis/Broncholitis
_____ Cancer
_____ Cholesterol/Triglyceride Disorder
_____ COPD/Pulmonary Diseases
_____ Congestive Heart Failure
_____ Depression
_____ Diabetes
_____ Drug Addiction/Dependency
_____ Fainting/Dizzy Spells
_____ Gallbladder Disease
_____ Glaucoma
_____ Headaches
_____ Hearing Problems
_____ Hiatal Hernia
_____ High Blood Pressure/ Hypertension
_____ Kidney Disease/Uremia
_____ Kidney Stones
_____ Low Blood Pressure/Hypotension
_____ Lung Disease
_____ Fatigue
_____ Muscle Disease
_____ Psychiatric Illness
_____ Psychotic Illness
_____ Pulmonary Hypertension
_____ Renal Disease
_____ Seizure Disorder
_____ Sleep Disorders
_____ Stomach/GI Disorders
_____ Stroke
_____ Thyroid Disorders
_____ Tremor
_____ Ulcer Disease
_____ Urinary Infections
_____ Weight Fluctuations
_____ *NONE OF THE ABOVE*

Children, Ages 10 and Under

_____ Problems In-Utero
_____ Premature Birth/Complications
_____ Ear Infections
_____ Febrile Seizure
_____ *NONE OF THE ABOVE*

Surgeries

_____ Appendix Removal
_____ Blood Transfusions
_____ CABG (Heart Surgery)
_____ Gallbladder Removal
_____ Hernia Repair
_____ Hysterectomy
_____ Pacemaker
_____ Tonsils Removed
_____ Tubal Ligation
_____ TURP
_____ Stomach Surgery
_____ Thyroid Surgery
_____ Spleen Surgery
_____ *NONE OF THE ABOVE*

Please check all that apply to your family medical history:

	Deceased	Diabetes	Asthma	Cancer	Hypertension	Coronary Artery Disease	None Listed
Mother	_____	_____	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____	_____	_____
Sibling	_____	_____	_____	_____	_____	_____	_____

Please check social history below:

Smoker _____ Yes _____ No

Alcohol _____ Never _____ Rarely _____ Occasional _____ Heavy

Recently Traveled Abroad: _____ Yes _____ No

Current Medications: _____

_____

_____