FAST TRACK
URGENT CARE CENTER

Last Name: _____ First Name: _____

Date of Birth: _____ Date of Visit: _____

Address:_____Apt #:_____City:_____State:_____Zip: _____

Home Phone:_____Cell Phone: _____

Work Phone:_____Email: _____

Reason for your visit today: _____

Is this an injury resulting from a work or motor vehicle accident? ☐ YES ☐ NO

Primary Care Physician (PCP) Name:_____
Please note we routinely send correspondence to PCP for continuity of care.

PCP Office Location:_____ PCP Office Phone:_____

Preferred Pharmacy:_____

Location (Cross streets): _____ Pharmacy Phone:_____

☐ **The above information is correct and accurate**
☐ **I have updated or changed the above demographic information**

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 our staff immediately.

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
☐ Post Nasal Drip
☐ Throat Swelling
☐ Dental Pain
☐ Neck Stiffness
☐ Swollen Neck Glands
☐ Chest Pain (Cardiac)
☐ 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 Stool
☐ 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
_____
_____
_____
_____

_____ _____
Patient Signature or Signature of Authorized Representative of Patient Date