TGH URGENT CARE powered by FAST TRACK

Last Name: _____ First Name: _____

Date of Birth: _____ Date of Visit: _____

Age:_____ Sex: ☐ MALE ☐ FEMALE

Race/ Ethnicity:_____ Preferred Language, if other than English: _____

Address:_____ Apt #:_____ City:_____ State:_____ Zip: _____

Home Phone:_____ Cell Phone: _____

Work Phone:_____ Email: _____

Social Security Number:_____ Marital Status: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

Reason for your visit today: _____

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

Emergency Contact Name:_____ Relationship: _____

Emergency Contact Phone: _____

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:_____

In order to process your claim, please complete below if the patient is NOT the POLICY HOLDER on your insurance.

Policy Holder's Name:_____ Relationship: _____

Insured's SSN:_____ Insured's Date of Birth: _____

Address:_____ Apt #:_____ City:_____ State:_____ Zip: _____

Main Phone: _____

Healthcare services that are respectful of, and responsive to, the health beliefs, cultural practices and linguistic needs of a diverse patient group can bring about positive health outcomes. Please let one of our clinical staff know should you have any cultural or religious requests or concerns.

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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 staff immediately.

Medications:

☐ None

Please list all medications that the patient is currently taking: _____

_____

_____

_____

_____

Please note: Our physicians will <u>not</u> write for, dispense or refill Schedule II or Schedule III drugs- including narcotics (such as hydrocodone, oxycodone, Percocet, Vicodin), benzodiazepines (such as Xanax, lorazepam), or amphetamines (such as Adderall, phentermine), written by other providers.

Past and Current Medical Conditions:

☐ None	☐ COPD/Emphysema	☐ High Blood Pressure	☐ Parkinson's Disease
☐ Acid Reflux / GERD	☐ Crohn's Disease	☐ High Cholesterol	☐ Peripheral Artery Disease
☐ Allergies	☐ Depression	☐ HIV/AIDS	☐ Prostate Cancer
☐ Alzheimer's Disease	☐ Diabetes	☐ Insomnia	☐ Rheumatoid Arthritis
☐ Anemia	☐ Eating Disorder	☐ Irritable Bowel (IBS)	☐ Seizures/Epilepsy
☐ Anxiety	☐ Enlarged Prostate	☐ Joint Injuries	☐ STD
☐ Arthritis	☐ Erectile Dysfunction	☐ Kidney Disease	☐ Skin Cancer
☐ Asthma	☐ Fibromyalgia	☐ Liver Disease	☐ Sleep Apnea
☐ ADHD	☐ Gallbladder Disease	☐ Low Back Pain	☐ Stroke
☐ Bleeding Disorders	☐ Gastrointestinal Ulcers	☐ Lung Cancer	☐ Thyroid Disease
☐ Breast Cancer	☐ Glaucoma	☐ Tuberculosis	☐ Vision Problems
☐ Broken or Fractured Bone(s)	☐ Gout	☐ Lupus	☐ Other / Not Listed
☐ Cataracts	☐ Hearing Problems	☐ Migraine	_____
☐ Clotting Disorder	☐ Heart Attack	☐ Obesity	_____
☐ Colon/Rectal Cancer	☐ Heart Disease	☐ Osteoporosis	_____
☐ Congestive Heart Failure	☐ Hepatitis	☐ Overactive Bladder	_____

Drug Allergies:

☐ None	☐ Depakote	☐ Morphine	☐ Other / Not Listed
☐ Amoxicillin	☐ Dilantin	☐ Other Antibiotics	_____
☐ Anti-Seizure Medicine	☐ Erythromycin	☐ Other Pain Killers	_____
☐ Aspirin	☐ Insulin	☐ Penicillin	_____
☐ Codeine	☐ Iodine	☐ Sulfa	_____
☐ Contrast Dye	☐ Latex		

Surgeries or Procedures:

☐ None	☐ Colon/Bowel Surgery	☐ Kidney Surgery	☐ Tonsillectomy
☐ Angioplasty	☐ Cosmetic Surgery	☐ Mastectomy	☐ Tubal Ligation
☐ Appendectomy	☐ Gallbladder Surgery	☐ Neurosurgery	☐ Vasectomy
☐ Back Surgery	☐ Gastric Bypass	☐ Orthopedic Surgery	☐ Other / Not Listed
☐ Breast Biopsy	☐ Heart Surgery	☐ Pacemaker Implantation	_____
☐ Cardiac Stent / Catheterization	☐ Hernia Repair	☐ Prostate Surgery	_____
☐ Cataract Surgery	☐ Hysterectomy	☐ Sinus Surgery	_____
☐ Cesarean Section	☐ Joint Replacement	☐ Thyroid Surgery	_____

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Hospitalizations:

- ☐ None
- ☐ Alcoholism or Substance Abuse
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Injury
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Pneumonia
- ☐ Stroke
- ☐ Seizures / Epilepsy
- ☐ Thyroid Disease
- ☐ Other / Not Listed

_____
_____
_____
_____

Family Medical History:

	Father	Mother	Grandfather	Grandmother	Siblings	Children
Acid Reflux / GERD	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Blood Disorder / Blood Clots	☐	☐	☐	☐	☐	☐
Cancer(s)	☐	☐	☐	☐	☐	☐
Depression / Anxiety	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐	☐	☐	☐
Heart Disease / Heart Attack	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Liver Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Seizures or Epilepsy	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐

Other / Not Listed _____

Social History:

Are you a current smoker?	☐ Yes	☐ No
Do you drink alcohol?	☐ Yes	☐ No
Do you drink caffeine?	☐ Yes	☐ No

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
- ☐ Postnasal Drip
- ☐ Throat Swelling
- ☐ Dental Pain
- ☐ Neck Stiffness
- ☐ Swollen Neck Glands
- ☐ Chest Pain (Cardiac)
- ☐ Heart 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 Stools
- ☐ 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

_____