TGH URGENT CARE powered by FAST TRACK

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	☐ Runny Nose	☐ Abdominal Pain	☐ Loss of Consciousness
☐ Fever	☐ Nose Bleeds	☐ Nausea	☐ Weakness or Paralysis
☐ Fatigue	☐ Sore Throat	☐ Vomiting	☐ Tingling or Numbness
☐ Weight Loss (unintentional)	☐ Loss of Voice	☐ Diarrhea	☐ Dizziness
☐ Weight Gain (unintentional	☐ Post Nasal Drip	☐ Constipation	☐ Easy Bruising
☐ Headaches	☐ Throat Swelling	☐ Dark Tarry Stools	☐ Easy Bleeding
☐ Loss of Vision	☐ Dental Pain	☐ Blood in Stool	☐ Leg Cramps
☐ Blurring of Vision	☐ Neck Stiffness	☐ Pain with Urination	☐ Heat or Cold Intolerances
☐ Eye Pain	☐ Swollen Neck Glands	☐ Frequent Urinations	☐ Increased Thirst
☐ Eye Irritation or Redness	☐ Chest Pain (Cardiac)	☐ Strong Urge to Urinate	☐ Rash
☐ Itchy Eyes	☐ Palpitations	☐ Difficulty Urinating	☐ Itchy Skin
☐ Drainage from Eyes	☐ Leg Swelling	☐ Blood in Urine	☐ Dry Skin
☐ Earache	☐ Cough	☐ Urine Output Changes	☐ Lumps or Swelling
☐ Decreased Hearing	☐ Shortness of Breath	☐ Joint Pain	☐ Changes in Hair or Nails
☐ Ringing of Ears	☐ Wheezing	☐ Joint Swelling	☐ Depressed Mood
☐ Ear Discharge	☐ Coughing up Blood	☐ Muscle Aches	☐ Sleep Disturbances
☐ Sinus Pain or Pressure	☐ Loss of Appetite	☐ Neck Pain	☐ Other / Not Listed
☐ Nasal Congestion	☐ Painful Swallowing	☐ Back Pain	_____
			_____
			_____

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