

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.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Loss of Consciousness |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Nausea | <input type="checkbox"/> Weakness or Paralysis |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Tingling or Numbness |
| <input type="checkbox"/> Weight Loss (unintentional) | <input type="checkbox"/> Loss of Voice | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Weight Gain (unintentional) | <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Constipation | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Throat Swelling | <input type="checkbox"/> Dark Tarry Stools | <input type="checkbox"/> Easy Bleeding |
| <input type="checkbox"/> Loss of Vision | <input type="checkbox"/> Dental Pain | <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Leg Cramps |
| <input type="checkbox"/> Blurring of Vision | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Pain with Urination | <input type="checkbox"/> Heat or Cold Intolerances |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Swollen Neck Glands | <input type="checkbox"/> Frequent Urinations | <input type="checkbox"/> Increased Thirst |
| <input type="checkbox"/> Eye Irritation or Redness | <input type="checkbox"/> Chest Pain (Cardiac) | <input type="checkbox"/> Strong Urge to Urinate | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Difficulty Urinating | <input type="checkbox"/> Itchy Skin |
| <input type="checkbox"/> Drainage from Eyes | <input type="checkbox"/> Leg Swelling | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Dry Skin |
| <input type="checkbox"/> Earache | <input type="checkbox"/> Cough | <input type="checkbox"/> Urine Output Changes | <input type="checkbox"/> Lumps or Swelling |
| <input type="checkbox"/> Decreased Hearing | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Changes in Hair or Nails |
| <input type="checkbox"/> Ringing of Ears | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Depressed Mood |
| <input type="checkbox"/> Ear Discharge | <input type="checkbox"/> Coughing up Blood | <input type="checkbox"/> Muscle Aches | <input type="checkbox"/> Sleep Disturbances |
| <input type="checkbox"/> Sinus Pain or Pressure | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other / Not Listed |
| <input type="checkbox"/> Nasal Congestion | <input type="checkbox"/> Painful Swallowing | <input type="checkbox"/> Back Pain | |

Patient Signature or Signature of Authorized Representative of Patient

Date

T 813.925.1903 | FastTrackUrgentCare.com | Open 8 a.m. – 8 p.m. 7 days a week
 Wesley Chapel | Carrollwood | Westchase | South Tampa | Downtown @ The Heights
 Riverview | St. Petersburg | Seminole | Brandon