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:_____City:_____State:_____Zip: _____

Please include Apartment or Unit Number if applicable

Home Phone:_____ Mobile Phone: _____

Work Phone:_____ Email: _____

Social Security Number:_____Marital Status: ☐SINGLE ☐MARRIED ☐WIDOWED ☐DIVORCED

Emergency Contact Name:_____ Relationship: _____

Emergency Contact Mobile Phone: _____Emergency Contact Home Phone: _____

Primary Care Physician (PCP) Name:_____

Please note we routinely send correspondence to PCP for continuity of care.

PCP Office Location:_____ PCP Office Phone:_____

Reason for your visit today: _____

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

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

Policy Holder's Name:_____Relation to Patient: _____

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

Address:_____City:_____State:_____Zip: _____

Please include Apartment or Unit Number if applicable

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** OR 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.

Please select your preferred option if any medications are prescribed during your visit today:

☐ Dispensed In-Office

☐ Same Day/Next Day Delivery through Capsule Pharmacy

☐ Send to local pharmacy

Preferred Pharmacy Name:_____

Location (Cross streets): _____Pharmacy Phone:_____

Drug Allergies: ☐ **None**

- ☐ Amoxicillin
- ☐ Anti-Seizure Medicine
- ☐ Aspirin
- ☐ Codeine
- ☐ Contrast Dye
- ☐ Depakote
- ☐ Dilantin
- ☐ Erythromycin
- ☐ Insulin
- ☐ Iodine
- ☐ Latex
- ☐ Morphine
- ☐ Other Antibiotics
- ☐ Other Pain Killers
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other / Not Listed

_____

_____

_____

_____

_____

Past and Current Medical Conditions: ☐ **None**

- ☐ Anemia
- ☐ Aneurysm
- ☐ Anxiety
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asbestos exposure
- ☐ Asthma
- ☐ Bipolar disorder
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Cataracts
- ☐ Congestive Heart Failure (CHF)
- ☐ Clotting disorder
- ☐ Colon polyps
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Blood transfusion
- ☐ Burn injury
- ☐ Carpal tunnel
- ☐ Chronic pain
- ☐ DVT or blood clot
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Emphysema
- ☐ Gall Bladder Disease
- ☐ Headaches
- ☐ Heart murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ ICD/Defibrillator
- ☐ Inflammatory bowel disease
- ☐ Kidney disease
- ☐ Leukemia
- ☐ Glaucoma
- ☐ Irritable bowel syndrome
- ☐ Low back pain
- ☐ Myocardial infarction – Heart attack
- ☐ Neuropathy
- ☐ Osteoarthritis
- ☐ PPD positive - Tuberculosis
- ☐ Mental disorder
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pancreatitis
- ☐ Peptic Ulcer
- ☐ Pneumonia
- ☐ Seizures
- ☐ Sleep Apnea
- ☐ Sleep disorder/Insomnia
- ☐ STD
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ UTI
- ☐ Varicose veins
- ☐ Rheumatoid arthritis
- ☐ Seasonal/Environmental allergies
- ☐ Sickle cell anemia
- ☐ Spina bifida
- ☐ Substance abuse
- ☐ Trauma/violence
- ☐ Other / Not Listed

_____

_____

_____

_____

_____

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Surgeries or Procedures: ☐ None

- ☐ Appendectomy
- ☐ Brain surgery
- ☐ Breast surgery
- ☐ CABG
- ☐ Cholecystectomy
- ☐ Colonoscopy
- ☐ C-Section
- ☐ Esophagus surgery
- ☐ Colon surgery
- ☐ Cosmetic surgery
- ☐ Eye surgery
- ☐ Fracture surgery
- ☐ Heart Cath
- ☐ Heart surgery
- ☐ Hernia repair
- ☐ Hysterectomy
- ☐ Joint replacement
- ☐ Kidney transplant
- ☐ Liver biopsy
- ☐ Liver surgery
- ☐ Lung transplant
- ☐ Small intestine surgery
- ☐ Spine surgery
- ☐ Tubal ligation
- ☐ Valve replacement
- ☐ Other / Not Listed
  _____
  _____
  _____
  _____
  _____

Family Medical History:
☐ Unknown ☐ Adopted

	Father	Mother	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Birth Defects	☐	☐	☐	☐	☐	☐	☐	☐
Cancer(s)	☐	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Early Death	☐	☐	☐	☐	☐	☐	☐	☐
Hearing loss	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease/Heart Attack	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐	☐	☐
Learning disabilities	☐	☐	☐	☐	☐	☐	☐	☐
Mental illness	☐	☐	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐	☐
Miscarriages/Stillbirths	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Vision loss	☐	☐	☐	☐	☐	☐	☐	☐
Other/Not Listed:	_____							

Social History:

Tobacco Use	☐Current	☐ Former	☐Never
Alcohol Use	☐Yes	☐ Not Currently	☐Never
Drug Use	☐Yes	☐ Not Currently	☐Never

Review of Systems:

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

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AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION

Last Name: _____ First Name: _____

Date of Birth: _____

I authorize and request the following organization to release information as stated below from the patient health information record:

Information Requested FROM:

☐ TGH Urgent Care powered by Fast Track

Or

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

Information Released TO:

☐ Self

☐ TGH Urgent Care powered by Fast Track

Fax Number: 813-749-8370

Or

Name: _____

Address: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

Information to be Released:

- ☐ Diagnostic Imaging ☐ All ☐ From Date(s): _____
- ☐ Lab Results ☐ All ☐ From Date(s): _____
- ☐ Progress Notes ☐ All ☐ From Date(s): _____
- ☐ Other, specify: _____
- ☐ Entire Medical Record. No limitations placed on dates, history of illness or diagnostic and therapeutic information for treatment for alcohol and drug abuse as protected by Federal Regulation 42CFR, Part II; psychiatric/psychological information and HIV/AIDS related information including testing per FS 90.503, 381.004, and 394.459.

Authorization for General Release of Information:

I understand that I have the right to revoke this authorization at any time. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form to assure treatment or payment. I understand I can cancel this authorization at any time in writing to any TGH Urgent Care powered by Fast Track location or by mail to 3301 W Gandy Blvd Tampa, FL 33611. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled. Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

_____ _____

Patient Signature or Signature of Authorized Representative of Patient **Date**