

Arlington Urgent Care Center

Patient's Name _____ Date of Visit _____

Reason for Visit: _____

Date of Birth _____ Height _____ Weight _____ Date of last Tetanus _____

Females: Date of last period _____ Pregnant ___Y ___N Breast feeding ___Y ___N

Pain Scale (0 to 10) 10 is worst # _____ Primary Care Physician _____

Allergies

Check if None _____

1 _____

2 _____

3 _____

4 _____

Past Medical History (list all past and present medical conditions) (example asthma, diabetes, high blood pressure, etc.)

Check if None _____

1 _____

2 _____

3 _____

4 _____

Current Medications

Check if None _____

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

Review of Systems (check all that apply)

Problems with:	No	Yes	Explain
General Health	_____	_____	_____
Eyes	_____	_____	_____
Ears, Nose, Throat	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
Kidney/Bladder	_____	_____	_____
Musculoskeletal	_____	_____	_____
Skin	_____	_____	_____
Neuro/Psychological	_____	_____	_____

Family History (check all that apply)

_____ Heart Disease _____ Stroke _____ Diabetes _____ Other

Social History Smoke _____ N _____ Y (pack/day _____) Drink Alcohol _____ N _____ Y

(How often _____ socially, _____ daily) Use recreational drug _____ N _____ Y

Anything else you would like us to be aware of? _____

Staff Use Only BP _____ P _____ R _____ T _____ O2 Sat _____

Labs: _____