Champlain Medical Urgent Care

Patient Name: _____

Yes	No	List allergies you have:
		Drug Allergies (specify):

Yes	No	List medications you take:
		Medications (specify):
1.		
2.		
3.		
4.		
5.		

Yes	No	Do you have any of the following?
		Cancer History
		Asthma
		Heart Disease
		Depression / anxiety
		Diabetes
		High Cholesterol
		High Blood Pressure
		Heartburn
		Other:

Yes	No	Have you had Surgeries or Operations?
		Surgeries (specify):

Yes	No	Do parents/siblings have any of the following?
		Cancer or Leukemia:
		Diabetes:
		Heart Disease:
		High Blood Pressure:
		Strokes:
		Mental Illnesses:

Yes	No	Do you use alcohol, drugs or smoke?
		Tobacco Use: How much ? _____ Day.
		Alcohol Use: How much ? _____ Day..

Yes	No	Are you employed?
		Employer:
		Position?

Yes	No	Menstrual History (woman):
		Are you pregnant?
		Last menstrual date?
		Last pap smear date?
		Left or right handed? ❑ Left ❑ Right
		Last Tetanus shot date?

Are you experiencing any of the following conditions/symptoms TODAY?

Yes	No	CONSTITUTIONAL
		Change in appetite
		Chills
		Fatigue
		Fever
Yes	**No**	**EYES AND VISION**
		Blurred vision
		Eye pain
Yes	**No**	**EARS, NOSE , THROAT, TEETH**
		Dizziness
		Ear pain
		Nasal congestion
		Sore throat
Yes	**No**	**CARDIOVASCULAR / HEART**
		Chest pain or pressure
		Fainting
		Irregular heart beat
Yes	**No**	**RESPIRATORY / LUNGS**
		Cough
		Shortness of breath
		Wheezing
Yes	**No**	**GASTROINTESTINAL SYSTEM**
		Abdominal pain
		Diarrhea
		Nausea
		Urinary / Bowel changes
		Vomiting

Yes	No	GENITOURINARY
		Frequent urination
		Painful urination
Yes	**No**	**MUSCULOSKELETAL**
		Joint pain
		Muscle pain
Yes	**No**	**SKIN**
		Rash / Itching
		Skin sores
Yes	**No**	**NEUROLOGICAL**
		Headache
		Light headedness
		Numbness
		Poor balance
		Tingling
		Weakness
Yes	**No**	**PSYCHIATRIC**
		Anxiety/Nerves
		Depression
Yes	**No**	**ENDOCRINE SYSTEM**
		Diabetes
		Hyper or hypothyroid
Yes	**No**	**HEMATOLOGIC/BLOOD DISORDERS**
		Anema
		Swollen glands
Yes	**No**	**IMMUNE SYSTEM**
		Frequent Infections

HOW CAN WE HELP YOU TODAY?

Signature: _____ **Date:** _____

Patient Vitals: Chief Complaint _____ Height ____ Weight ____ Temp ____ BP ____ / ____ Pulse ____ O2sat % ____ Room ____