Lincoln Urgent Care

NORTH SMITHFIELD URGENT CARE

PATIENT INFORMATION

First Name: _____ MI: _____ Last Name: _____

Date of Birth: ___/___/_____ Age: _____ **SS#**: _____-_____-_____ _____Male _____Female ____Transgender

Ethnicity: _____ Asian _____ Black _____ Caucasian/White _____ Latino/Spanish _____ Other

***If patient is a minor (under the age of 18) who may authorize treatment:

Name: _____ **Relationship**: _____

CONTACT INFORMATION

Home Address: _____ **City**: _____ **State**: ____ **Zip**: _____

Mailing Address/PO Box if different from above: _____

Home Phone: (____) _____ - _____ **Cell**: (_____) _____ - _____ **Email Address**: _____

OK to leave message _____Yes _____No

Emergency Contact Name: _____ **Phone**: _____

Relationship: _____ Permission to give Medical Information to Emergency Contact: ___ Yes ___No

Primary Care Physician Name: _____ **Phone**: _____

Your Pharmacy Name: _____ **Pharmacy Phone #:** (____) _____ -_____

X **PATIENT SIGNATURE**: _____ **Date**: _____/ _____/ _____

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MEDICAL QUESTIONNAIRE

Patients Name: _____ **Date:** _____

Reason for today's Visit: _____

Did your symptoms begin within the last 24 hours _____ Yes _____ No

Have you been treated for these symptoms previously _____ Yes _____No

Is this visit due to an Accident/Injury: ___ Yes __ No Type of Accident/Injury: ___Work ____ Auto ___ Other

Social History: Smoker _____ Yes _____No Packs per day: _____

Alcohol _____ Yes _____No If yes how often do you drink: ____ daily ____weekly ____ socially

History of/or current recreational drug use? _____ Yes _____ No

Please list any medication *Allergies*: _____ _____ _____

Are you allergic to any of the following: _____ Latex _____ Eggs

Please List All Medications/Vitamins/Supplements: _____ _____

_____ _____ _____

_____ _____ _____

X PATIENT SIGNATURE: _____ **Date**: _____/ _____/ _____

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MEDICAL HISTORY

Patients Medical History: Please circle all that apply.

Anemia	**Arthritis**	**Asthma**	**Atrial Fibrillation**
Blood Clots-DVT	**Cancer (type)**	**COPD**	**Concussion**
Crohn's disease	**Depression/Anxiety**	**Diverticulitis**	**Diabetes: type I or II**
Emphysema	**Gout**	**Heart Disease**	**Hepatitis: A B or C**
High blood pressure	**High Cholesterol**	**HIV or AIDS**	**Irritable Bowel syndrome**
Kidney disease	**Multiple sclerosis**	**Osteoporosis**	**Parkinson's**
Rheumatoid Arthritis	**Stroke**	**Thyroid disease**	**Other**

Please List Major Surgeries: _____ _____ _____ _____ _____

_____ _____ _____ _____ _____

X PATIENT SIGNATURE: _____ **Date**: _____/ _____/ _____