QuickCARE Of Ruston

Patient Name: _____ Date of Birth: _____ Age: _____

Medication Allergies: _____

Medications Taking: _____

Is this visit the result of a work related accident? ☐Yes ☐No Have you been here before? ☐Yes ☐No

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ Acid Reflux	☐ Diabetes	☐ Migraine Headaches
☐ Anemia	☐ Down Syndrome	☐ Seizures
☐ ADHD	☐ Heart Attack	☐ Skin Disorders
☐ Anxiety / Depression	☐ High Cholesterol	☐ Stroke
☐ Asthma	☐ High Blood Pressure	☐ Thyroid Disease
☐ Cancer	☐ Kidney Disease	☐ List Other: _____
☐ COPD	☐ Liver Disease	_____
☐ NO PAST MEDICAL HISTORY		_____

PAST SURGERIES (PLEASE CHECK ALL THAT APPLY)

☐ Appendectomy	☐ Gall Bladder Removal	☐ Hysterectomy
☐ Cardiac Stent	☐ Tubes in ears	☐ Thyroidectomy
☐ Heart Bypass	☐ Tubal Ligation	☐ Tonsillectomy / Adenoidectomy
☐ C-Section	☐ Hernia Repair _____	☐ List Other: _____
☐ NO PAST MEDICAL HISTORY	_____	_____

SOCIAL HISTORY

☐ Parent Smokes (pediatric patients only)	
☐ Nonsmoker	☐ Do not drink alcohol
☐ Former Smoker / # Of Years Smoked:	☐ Occasional Drinker
☐ Occasional Smoker / # Of Years Smoked:	☐ Daily Drinker
☐ Daily Smoker / # Of Years Smoked:	

CURRENT SYMPTOMS (PLEASE CHECK ALL THAT APPLY)

Constitutional	Pulmonary	Pain / Injury
☐ Fever (Max Temp:)	☐ Shortness of Breath	☐ Back Pain
☐ Chills	☐ Cough	☐ Headache
☐ Body Aches	**Cardiovascular**	**General Urology**
Eyes / ENT	☐ Chest Pain (NOTIFY STAFF!)	☐ Burning with Urination
☐ Eye Problems	☐ Passed Out	☐ Frequent Urination
☐ Ear Problems	☐ Skin Problems (Rash)	☐ List Other: _____
☐ Sore Throat	☐ Laceration	_____
☐ Sinus Congestion	☐ Abscess (Boil)	_____
WHEN DID SYMPTOMS START? (Use a number)	**minutes ago / hours ago / days ago / weeks ago**	

Vital Signs (Staff Use ONLY)

BP:	Pulse:	RR:	Pulse Ox:	Immunizations up to date: ☐ Yes ☐ No
Temperature: _____ ☐ Oral ☐ Ax ☐ Rectal				Tetanus up to date: ☐ Yes ☐ No
Height: _____ (inches)	Weight: _____ LBS			Last Menstrual Period:
Pharmacy:				
Strep:	Flu:	UA / UPT:	Celestone: mg	Toradol mg / Decadron mg

Print Form