i-Care Urgent Care
Patient Information

Welcome to i-Care Urgent Care. To better serve you, please complete as much as possible.

NAME: _____

MAIN PROBLEM (be brief): _____

_____

PAST MEDICAL HISTORY: ☐ None

___ Headaches
___ Heart problems
___ Tuberculosis (TB)
___ Seizures
___ High blood pressure
___ Diabetes
___ Other problems

PAST SURGICAL HISTORY: ☐ None

___ Orthopedic Surgery
___ Cesarean section
___ Appendectomy
___ Tonsillectomy
___ Gallbladder
List any others here:

MEDICATIONS: ☐ None

Frequency of use and dosage

ALLERGIES TO MEDICATIONS: ☐ None

Describe reaction

CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING IN THE LAST 24 HOURS:

___ Fever	___ Eye problems	___ Nausea	___Urinary problems
___ Sore throat	___ Ear problems	___ Vomiting	___ Abdominal pain
___ Cough	___ Irregular heart beat	___ Diarrhea	___ Weakness
___ Difficulty breathing	___Chest pain	___ Shortness of breath	___ Headache

SOCIAL HISTORY:

Do you smoke? □ Yes □ No
Drink alcohol □ Yes □ No
Drink caffeine? □ Yes □ No

FAMILY HEALTH HISTORY:

Mother: _____
Father: _____
Sibllings: _____
How much per day?
Exercise/Frequency?:

PROBLEM (please list below):

_____

PATIENT SIGNATURE: **DATE:**

STAFF USE ONLY :

Vital Signs (to be done by i-Care)

Weight _____ **Pulse Ox**_____
Height _____ **Blood Pressure**____
Heart Rate_____ **Temp**_____