Lincoln 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 <u>All</u> Medications/Vitamins/Supplements: __________________________ ________________________

__________________________ ________________________ ______________________

__________________________ ________________________ ______________________

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

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**: _____/ _____/ _____