Date: _____

N E

LUCEDALE URGENT CARE

ROOM #: _____

Nurse Use Only:
Height: _____
Weight: _____
Blood Glucose: _____
Accu √: _____
Dexcom: _____

Nurse Use Only:
HR: _____
BP: _____
RR: _____
02 Sat: _____%
Temp: _____

Phone Number: (____) _____
Area Code Number

Preferred Name: _____

Primary Care Doctor: _____

Reason for Visit

Please write any symptoms you are having on the on the following line:

_____

Allergies / Medicine Allergies: _____

Pharmacy: _____

The pharmacy that you list is where your medications will be sent if any are prescribed at this visit.

Current Medications Please List ALL

If you are not taking any medications, please write NONE below.

_____ _____

_____ _____

_____ _____

_____ _____

Is there any chance you could be pregnant? Yes or **No (circle one)**

(Any female between the ages of 8-80 seen for lower back pain, nausea, or abdominal pain who has not had a hysterectomy will have a pregnancy test)

Emergency Contact: _____ Relationship to patient: _____

Emergency Contact Phone Number: _____

I authorize my medical/financial records to be released/discussed: Yes or **No (circle one)**

If yes, please list authorize persons: _____

Relationship to patient: _____

I attest that my responses are true. Print Patient's Name: _____

Print name of responsible person signing for patient if patient is a minor: _____

Signature: _____ **Date:** _____

PERSONAL MEDICAL HISTORY

1) Personal Medical History: Conditions - current or treated in the past. (Check all that apply)

- ☐ Allergies J30.2
- ☐ Anemia D64.9
- ☐ Anxiety F41.9
- ☐ Arthritis M13.80
- ☐ Asthma J45.909
- ☐ Atrial Fibrillation I48.91
- ☐ Bipolar Disorder F31.9
- ☐ Cancer (add comments below)
- ☐ Cataracts H25.9
- ☐ Chronic Fatigue R53.82
- ☐ Congestive Heart Failure I50.9
- ☐ COPD / Breathing Problems J44.9
- ☐ Coronary Artery Disease I25.10
- ☐ Deep Vein Thrombosis/Pulmonary Embolism Z86.718
- ☐ Dementia / Memory Loss F03.90
- ☐ Depression F32.A
- ☐ Diabetes Type 1 E10.9
- ☐ Diabetes Type 2 E11.9
  - ☐ on insulin with Diabetes Type 2 Z79.4
- ☐ Diverticulosis/Diverticulitis Z87.19
- ☐ Fibromyalgia M79.9
- ☐ Glaucoma H40.9
- ☐ Gout M10.9
- ☐ Other (add comments below)
- ☐ Heart Attack Z86.74
- ☐ Heart Disease I51.9
- ☐ Heartburn / Gastric Reflux K21.9
- ☐ Hepatitis K73.9
- ☐ Hernia Z87.19
- ☐ High Cholesterol E78.5
- ☐ HIV Z71
- ☐ Hypertension I10
- ☐ Hypothyroidism E03.9
- ☐ Irregular Heart Rythm/Heart Arrythmias I49.9
- ☐ Kidney Disease (add stage in comments)
  - ☐ on dialysis Z99.2
- ☐ Kidney Stones Z87.442
- ☐ Liver Disease K76.9
- ☐ Obesity E66.9
- ☐ Osteoarthritis M19.90
- ☐ Osteoporosis M81.0
- ☐ Pneumonia Z87.01
- ☐ Rheumatoid Arthritis M06.9
- ☐ Seizures G40.909
- ☐ Stroke Z86.73
- ☐ Thyroid Disease E07.9
- ☐ Urinary Tract Infections Z87.440
- ☐ None of the above / No past medical history to report

Comments:

2) Surgical History (Check all that apply)

- ☐ Appendectomy (Appendix)
- ☐ Adenoidectomy (Adenoids)
- ☐ Breast Augmentation/Reduction
- ☐ C-Section
- ☐ Cardiac Bypass Surgery
- ☐ Cholecystectomy (Gall Bladder)
- ☐ Ear Tubes
- ☐ Gastric Bypass/Sleeve
- ☐ Hernia Repair
- ☐ Hysterectomy
- ☐ Tonsillectomy
- ☐ Other (add comment below)

☐ No past surgical history

Comments:

Initials: _____

3) Family History (Check Yes or No / Do not leave any blank)

	Yes	No		Yes	No
Arthritis	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Obesity	☐	☐
Dementia	☐	☐	Osteoporosis	☐	☐
Depression	☐	☐	Stroke	☐	☐
Diabetes - Type 1	☐	☐	Substance Abuse	☐	☐
Diabetes - Type 2	☐	☐	Cancer (add comments below)	☐	☐
Heart Disease	☐	☐			
High Blood Pressure	☐	☐			
High Cholesterol	☐	☐			

Comments:

4) Vaccination Status:

Influenza ☐ Vaccinated ☐ Not Vaccinated

Covid 19 ☐ Fully Vaccinated ☐ Partial ☐ Not Vaccinated ☐ Booster

Brand(s) ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson

5) Smoking Status

☐ Never Smoker
☐ Former Smoker
☐ Current Smoker

☐ Cigarettes
☐ Vape
☐ Other (illicit drugs)

How many packs per day do you smoke? _____

Has Smoked For: _____ years Quit date, if applicable: _____

Comments:

6) Oral Chewing/Tobacco Use: YES ☐ NO ☐ If yes, how many: _____ years

7) Alcohol Use: Do you drink alcohol? YES ☐ NO ☐

How many drinks per week? 1-3 ☐ 3-5 ☐ 5-8 ☐ Greater than 8 ☐ ☐ Other: _____

I attest that my responses are true. Print name: _____

Print name of responsible person signing for minor patient: _____

Signature: _____