ACADIANA URGENT CARE CENTER

Reason for Visit and Medical History

Patient Name:_____ Reason for Visit: _____

Date of Birth: _____/_____/_____ **Outside of the Country in the last 6 weeks?** Y / N **Work Related Injury?** Y / N

Please check all that apply to you (conditions you have been diagnosed with and/or being treated for):

____ Acid Reflux	____ Depression	____ Heart Attack	____ Kidney Disease
____ Asthma	____ Diabetes: Type I Type II	____ High Blood Pressure	____ Stroke
____ Cancer Type:_____	____ High Cholesterol	____ Hypothyroid	____ Other _____

Drink Alcohol (amount/freq) ____/____ Smoke (amount/freq) ____/_____ Do you use an E-cigarette? Y / N

Current Medication? Y / N (list) _____

Preferred Pharmacy & Location_____

Previous Surgeries & Dates? Y / N (list)_____

Other Medical History: _____

Medication Allergies? Type of reaction (rash, itching, etc.)
(list)_____

******WE DO NOT SEE ANY MOTOR VEHICLE ACCIDENTS******
(Includes automobiles, motorcycles, ATV's, dirt-bikes, golf-carts)

Please circle all that apply for TODAY'S visit

CONSTITUTIONAL	CARDIO	GU	HEMA/LYMPH
Chills	Chest pain	Pain with urination	Bleeding
Decreased Appetite	Shortness of breath on exertion	Blood in urine	Easy bruising
Fatigue/weakness	Leg swelling	Frequent urination	Painful lymph nodes
Fever	Palpitations	Vaginal bleeding	Swollen lymph nodes
Sweating	**RESPIRATORY**	Vaginal discharge	**ALLERGY/IMMUN**
Weight loss	Asthma	Vaginal itching/irritation/odor	Hives
EYES	Cough	**MUSC/SKEL**	Itching skins
Blurred vision	Pain with cough/breathing	Back pain	Itching eyes
Eye discharge	Shortness of breath	Edema	Seasonal allergies
Eye pain/pressure	Sputum	Joint pain	Sneezing
Eye redness	(color:_____)	Muscle spasm	Watery eyes
Eyelid swelling	Wheezing	Muscle weakness	**NEURO**
Glasses or contacts	**GI**	Neck pain	Dizziness
ENT/MOUTH	Abdominal pain	Joint swelling/redness	Fainting
Ear pain	Constipation	**SKIN/BREAST**	Headache
Hearing loss	Cramping	Laceration	Loss of consciousness
Hoarseness	Diarrhea	Abscess/Boil	Numbness
Post-nasal drip	Hemorrhoids	Discharge/drainage	Tingling
Sinus drainage	Nausea	Redness of skin	**PSYCH**
Sinus pressure	Rectal bleeding	Itch	Anxiety
Sore throat	Ulcers	Lesions	Depression
Toothache	Vomiting	Rash	Insomnia

Females Only: Date of last menstrual cycle: _____ Taking birth control? Y / N Are/Could you be pregnant? Y / N