SIMEDHealth

NEW SIMEDHealth URGENT CARE / WORK COMP INJURY / AUTO ACCIDENT PATIENT VISIT

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **TODAY'S DATE:** _____

SELECT REASON FOR TODAY'S VISIT:

□ **URGENT CARE/MEDICAL VISIT FOR:** _____

□ **AUTOMOBILE ACCIDENT THAT OCCURRED ON:** ____/____/____
LIST BODY PART(S) INJURED IN AUTO ACCIDENT: _____

□ **WORKER'S COMPENSATION VISIT (Please answer all of the following questions):**

CURRENT EMPLOYER: _____ □ FULL TIME □ PART TIME DATE OF HIRE: _____

TYPE OF JOB/JOB TITLE OR POSITION: _____ DATE OF INJURY: _____

LIST BODY PART(S) INJURED: _____
_____

HAVE YOU EVER HAD A PREVIOUS ON-THE-JOB INJURY? □ YES □ NO
IF YES, PLEASE LIST DATE OF INJURY AND BODY PART(S) INVOLVED: _____
_____

HAVE YOU EVER HAD A PREVIOUS INJURY, PAIN, PROBLEMS WITH OR MEDICAL TREATMENT FOR THOSE BODY PARTS INVOLVED IN THIS RECENT ON-THE-JOB INJURY? □ YES □ NO
IF YES, PLEASE DESCRIBE WHICH BODY PART, THE TYPE OF TREATMENT, AND WHEN YOU LAST HAD PROBLEMS OR TREATMENT_____
_____

Have you been treated elsewhere for this RECENT condition/injury/illness? □ **YES** □ **NO**

If YES, (a) where were you treated? _____

(b) when were you treated? _____

PAST MEDICAL HISTORY (PLEASE PROVIDE AN ANSWER FOR EACH ONE):

*Diabetes	□ **NO**	□ **YES**	*Fibromyalgia	□ **NO**	□ **YES**
*Thyroid Disease	□ **NO**	□ **YES**	*Pace Maker	□ **NO**	□ **YES**
*Allergies (seasonal)	□ **NO**	□ **YES**	*Liver Disease	□ **NO**	□ **YES**
*Heart Disease	□ **NO**	□ **YES**	*Kidney Disease	□ **NO**	□ **YES**
*High Blood Pressure	□ **NO**	□ **YES**	*HIV / AIDS	□ **NO**	□ **YES**
*Vascular Disease	□ **NO**	□ **YES**	*Stroke	□ **NO**	□ **YES**
*Seizure Disorder	□ **NO**	□ **YES**	*Migraines	□ **NO**	□ **YES**
*Ulcers or Reflux Disease	□ **NO**	□ **YES**	*Lung Disease/Asthma	□ **NO**	□ **YES**
*Depression	□ **NO**	□ **YES**	***Cholesterol Problems	□ **NO**	□ **YES**
*Anxiety	□ **NO**	□ **YES**	*Sleep Apnea	□ **NO**	□ **YES**
*Chronic Pain Syndrome	□ **NO**	□ **YES If yes, where:** _____			
*Arthritis	□ **NO**	□ **YES If yes, where:** _____			
*Cancer	□ **NO**	□ **YES If yes, what type**: _____			
*Substance Addiction	□ **NO**	□ **YES If yes, what substance(s)**: _____			

*Any Other Medical Conditions (not listed above): _____
_____

SURGERIES IN YOUR LIFETIME (like Tonsillectomy, appendix removed, etc): □ NONE □ YES: _____
_____

****TURN OVER SHEET AND FILL OUT THE OTHER SIDE OF THE FORM****

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **TODAY'S DATE:** _____

FIRST CARE URGENT CARE
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PATIENT NAME: _____ **DATE OF BIRTH:** _____ **TODAY'S DATE:** _____

CURRENT MEDICATIONS: □ NONE □ YES (Including over the counter medications and birth control pill/shot):

_____

_____

MEDICATION ALLERGIES: □ NONE □ YES If yes, please list what medication(s) and reaction(s):

_____

LIST ANY MEDICAL DISEASES OR PROBLEMS IN YOUR FAMILY (DO NOT GIVE ANY FAMILY MEMBER'S NAMES):

□ **NO MEDICAL PROBLEMS IN MY IMMEDIATE FAMILY OR □ YES, LIST THE DISEASE FOR THE FAMILY MEMBER**

1. **MOTHER:** _____
2. **FATHER:** _____
3. **BROTHER(S):** _____
4. **SISTER(S):** _____

HABITS:

Do you smoke/chew tobacco: □ NO □ YES How much? _____ □ Quit _____

Do you consume alcohol: □ NO □ YES How much? _____ □ Quit _____

Do you use recreational drugs: □ NO □ YES What drug(s)? _____

REVIEW OF SYSTEMS: ***Check off those symptoms you are currently experiencing related to today's visit:***

GENERAL: □ Fever □ Chills □ Night Sweats □ Body Aches □ Fatigue □ Weakness
□ Weight Loss □ Weight Gain □ Bruise Easily □ Heat Intolerance □ Cold Intolerance

HEENT: □ Headache □ Lightheadedness/Dizziness □ Blurred Vision □ Eye Pain (□ Right □ Left)
□ Eye Redness (□ Right □ Left) □ Drainage from Eye (□ Right □ Left) □ Ear Pain (□ Right □ Left) □ Ear Discharge (□ Right □ Left)
□ Hearing Loss (□ Right □ Left) □ Ringing in the Ear (□ Right □ Left) □ Nasal Congestion □ Nasal Drainage
□ Post Nasal Drainage □ Sore Throat □ Difficulty Swallowing Foods □ Difficulty Swallowing Liquids □ Swollen Glands
□ Pus on Tonsils

CARDIAC: □ Chest Pain (sharp) □ Chest Pressure/Tightness □ Palpitations □ Rapid Heart Rate
□ Swelling of Hands (□ Right □ Left) □ Swelling of feet (□ Right □ Left)

RESPIRATORY: □ Cough □ Wheezing □ Shortness of Breath □ Sputum Production □ Coughing up blood □ Pain with deep inspiration

GI: □ Stomach Pain □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Blood in Stool □ Black Tarry Stools

GU: □ Burning with urination □ Urinary Frequency □ Urinary Urgency □ Blood in urine
□ Urinary Incontinence □ Discharge from Genitals □ Lesions/Sores on Genitals □ Abnormal Bleeding from Genitals

MS: □ Neck Pain □ Upper Back Pain □ Mid-Back Pain □ Low Back Pain
□ Muscle Cramps/Spasms (location: _____)
□ Joint Swelling (location: _____)
□ Joint Pain/Stiffness (location: _____)

NEURO: □ Numbness in Hands (□ Right □ Left) □ Numbness in Feet (□ Right □ Left)

PSYCHOLOGICAL: □ Depression □ Anxiety □ Difficulty Sleeping

VACCINE INFORMATION (MUST FILL OUT)

(a) Influenza Vaccine: Month: ____ and Year: _____ □ Did not have vaccine this season

(b) Pneumonia Vaccine: Month: ____ and Year: _____ □ Never had this vaccine before

FEMALE PATIENTS ONLY: Last Menstrual Period: _____

Are you currently on or using any birth control measures: □ NO □ YES

Are you currently pregnant or could you possibly be pregnant at this time? □ NO □ YES If yes, how far along in the pregnancy: _____

SIGNATURE OF PATIENT: _____ **DATE:** ____/____/____

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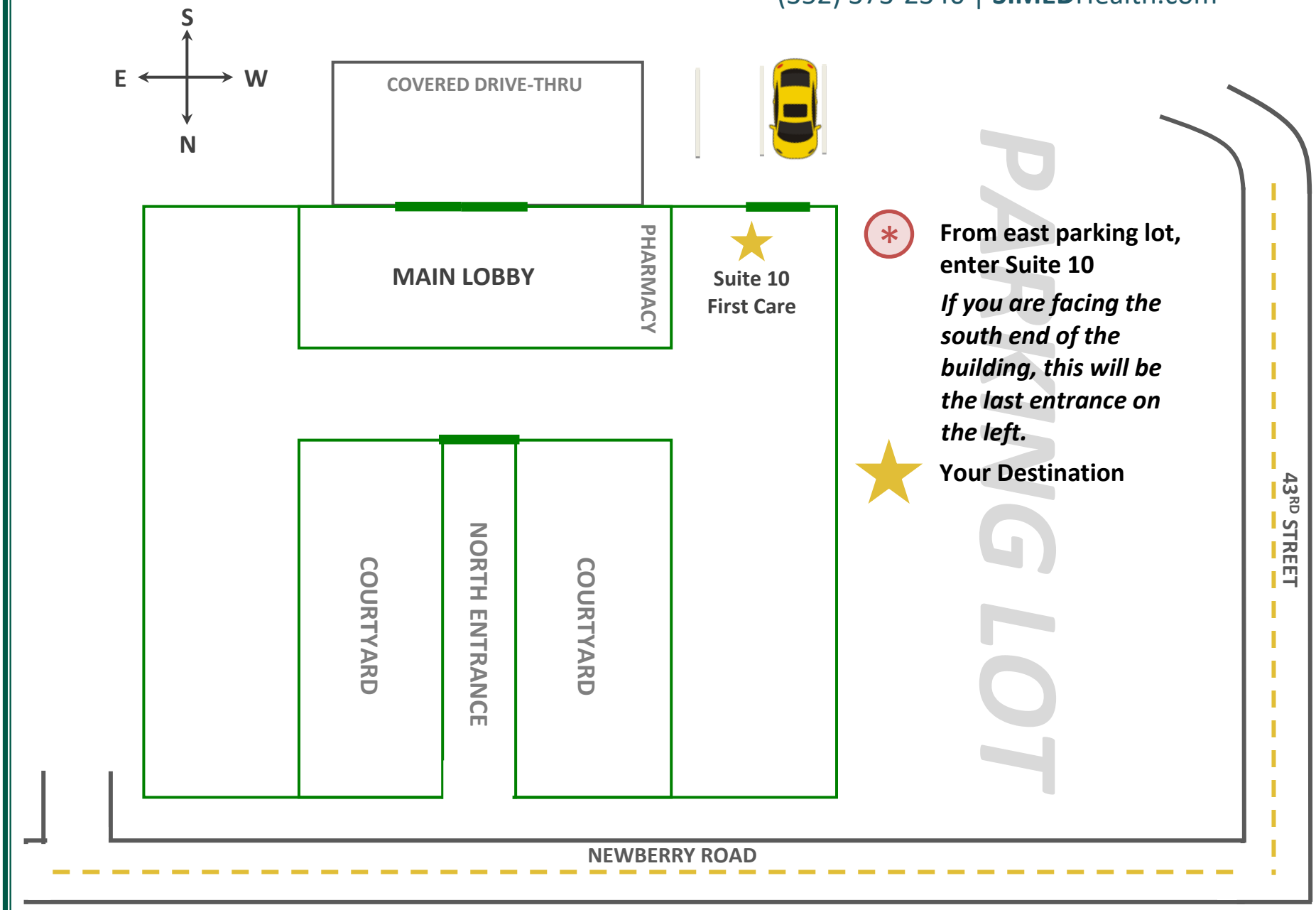

* **From east parking lot, enter Suite 10**

If you are facing the south end of the building, this will be the last entrance on the left.

Your Destination