HISTORY AND PHYSICAL

Patient Name: _____DOB: ____/____/____
Today's Date: ____/____/____

Briefly explain the reason for coming to Rapid Care Center (include duration, severity and location):

_____

_____

Is your visit related to a work injury? ☐ YES ☐NO

REVIEW OF SYSTEMS: If currently experiencing **NOW**, please check **ALL** that apply.

GENERAL

YES	NO	
☐	☐	Headache
☐	☐	Lethargy/Weakness
☐	☐	Chills/Night sweats
☐	☐	Fever
☐	☐	Fainting spells/unconscious
☐	☐	Weight loss
☐	☐	Dizziness

EYES

☐	☐	Wears glasses
☐	☐	Eyesight worsening
☐	☐	Double vision
☐	☐	Eye Pain

EARS/NOSE/THROAT

☐	☐	Deafness
☐	☐	Noise in ears
☐	☐	Congestion/sneezing
☐	☐	Sinus trouble/hay fever
☐	☐	Nose bleeds
☐	☐	Sore throat or tongue
☐	☐	Hoarse voice
☐	☐	Dental problem

STOMACH

YES	NO	
☐	☐	Trouble swallowing
☐	☐	Heartburn/Indigestion
☐	☐	Change in bowel habits
☐	☐	Loose Stool/diarrhea
☐	☐	Black/Bloody Stools
☐	☐	Frequent stomach pain
☐	☐	Vomiting blood
☐	☐	Constipation
☐	☐	Irritable bowel
☐	☐	Ulcers
☐	☐	Stomach/bowel cancer

KIDNEY PROSTATE

☐	☐	Frequent voiding
☐	☐	Burning on urination
☐	☐	Pus/blood in urine
☐	☐	Trouble starting urination
☐	☐	Dribble with cough/sneeze
☐	☐	Loss of urine control
☐	☐	Prostate disease/cancer
☐	☐	Sexual difficulty

HEART

YES	NO	
☐	☐	Chest pain with exertion
☐	☐	Heart attack

SKIN

☐	☐	Rashes
☐	☐	Birthmarks
☐	☐	Sores

OTHER_____
_____
_____
_____

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES_____
_____
_____
_____

CURRENT MEDICATIONS/DOSAGES INCLUDING OVER-THE COUNTER AND HERBAL MEDICATIONS:

The front desk can photocopy and attach your list of medications if you have it with you. ☐ **Check if none.**

1._____	**5.**_____	**9.**_____
2._____	**6.**_____	**10.**_____
3._____	**7.**_____	**11.**_____
4._____	**8.**_____	**12.**_____

ALLERGIES: Please list below as well as the reactions you experience. ☐ Check if none

1._____	**5.**_____	**9.**_____
2._____	**6.**_____	**10.**_____
3._____	**7.**_____	**11.**_____
4._____	**8.**_____	**12.**_____

PAST MEDICAL HISTORY: Please mark those that apply. ☐**Check here if none.**

YES	NO		YES	NO		YES	NO	
☐	☐	Convulsions or Seizures	☐	☐	Cardiac Angiogram or Echo	☐	☐	Herniated Disc or Sciatica
☐	☐	Epilepsy	☐	☐	PFO Repair	☐	☐	Shoulder Injury
☐	☐	Concussion	☐	☐	High Blood Pressure	☐	☐	Elbow Injury
☐	☐	Disabling Headaches	☐	☐	Asthma	☐	☐	Arm/wrist/hand Injury
☐	☐	Loss of Balance/Dizziness	☐	☐	Coughing up Blood	☐	☐	Hip/Leg/Ankle Injury
☐	☐	Severe Motion Sickness	☐	☐	Tuberculosis	☐	☐	Knee Injury or "Trick Knee"
☐	☐	Unconsciousness	☐	☐	Shortness of Breath	☐	☐	Foot Trouble or Injuries
☐	☐	Fainting Spells	☐	☐	Chronic Cough	☐	☐	Dislocations
☐	☐	Wear Contacts/Glasses	☐	☐	Pneumothorax	☐	☐	Swollen joints
☐	☐	Color Vision Defect	☐	☐	Lung Disease or Surgery	☐	☐	Broken Bones or Fractures
☐	☐	Eye Disease or Injury	☐	☐	Gallbladder Disease or Stones	☐	☐	Varicose Veins
☐	☐	Eye Surgery	☐	☐	Stomach Trouble or Ulcers	☐	☐	Muscle Disease or Weakness
☐	☐	Hearing Loss	☐	☐	Stomach Bleeding	☐	☐	Numbness or Paralysis
☐	☐	Ear Disease or Injury	☐	☐	Frequent Indigestion	☐	☐	Sleep Disorders
☐	☐	Ear Surgery	☐	☐	Jaundice	☐	☐	Diabetes
☐	☐	Perforated Eardrum	☐	☐	Liver Disease or Hepatitis	☐	☐	Goiter or Thyroid Disease
☐	☐	Difficulty Clearing	☐	☐	Rectal Bleeding/Blood in Stools	☐	☐	Blood Disease
☐	☐	Nose Bleed	☐	☐	Hemorrhoids (Piles)	☐	☐	Anemia: Sickle Cell or Other
☐	☐	Airway Obstruction	☐	☐	Gas Pains	☐	☐	Skin Rash or Disease
☐	☐	Hay Fever or Allergies	☐	☐	Crohn's Disease/Ulcerative Colitis	☐	☐	Staph Infections
☐	☐	Chest Pain	☐	☐	Rupture or Hernia	☐	☐	Tumor or Cancer
☐	☐	Heart Murmur	☐	☐	Kidney Disease	☐	☐	Claustrophobia
☐	☐	Rheumatic Fever	☐	☐	Kidney Stones	☐	☐	Mental Illness/Depression/Anxiety
☐	☐	Heart Attack	☐	☐	Protein, Sugar or Blood in Urine	☐	☐	Nervous Breakdown
☐	☐	Abnormal Heart Rhythm	☐	☐	Joint Pain/Arthritis	☐	☐	Any Sexually Transmitted Disease
☐	☐	Heart Disease	☐	☐	Back Strain or Injury	☐	☐	Contagious Disease
☐	☐	Cardiac Stent or Angioplasty	☐	☐	Spine Problems	☐	☐	Other Illness or Injury or Any Other Medical Condition

PLEASE EXPLAIN THE DETAILS OF EACH ITEM CHECKED YES_____

_____

_____

_____

SURGICAL HISTORY: Please mark those that apply. ☐**Check here if none.**

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Head/Neck/Breast	☐	☐	Heart/Lung	☐	☐	Abdominal/Pelvic	☐	☐	Spine	☐	☐	Bone/Joint

☐Other

Please provide procedure name and year: _____

SOCIAL HISTORY: Please mark those that apply. ☐**Check here if none.**

☐**Tobacco**: Cigs/day_____ Years of Use _____ ☐**Alcohol**: Drinks/day ____ Years of Use _____

☐Street/Non-prescribed Drugs ☐Sexually Active ☐ Recent travel _____

FEMALE PATIENTS: Last Menstrual Period: Month_____ Day _____

☐ I have a "**Do Not Resuscitate**" order in place ☐ I have an **Advance Directive** (Please provide front desk a copy)

FOR OFFICE USE ONLY

VITALS: **T**: _____ **BP**: _____ **P:** _____**R:** _____ **O2%**_____**HT:** _____**WT:** _____ **ACCUCHECK:** _____

_____

_____

_____

Initials MA/X-Ray Tech: _____ **Date & Time:** _____