EXECUTIVE URGENT CARE AT INDIAN WELLS

Name: _____ D.O.B. _____
Last First

Office use only

Date: _____ Patient Record #: _____ Insurance: _____

T_____ P_____ B/P_____ R_____ O2%_____ WT _____ HT_____

TO BE COMPLETED BY RETURNING PATIENT: Please complete the following information below

Primary Doctor: _____ PH: _____ Fax: _____

Local Pharmacy: _____ Pharmacy Location: _____

[Females Only:]

Menstrual History: Approx. first day of last menstrual cycle: _____

Chief complaint/ Reason for your visit _____

_____

Approx. onset of symptoms? _____

Any pain/ discomfort associated with problem? _____

Pain/ discomfort level: 1 2 3 4 5 6 7 8 9 10

Was this the result of a **work** injury? ☐Yes ☐ No

Medications: Strength/ Frequency – Please list **all** current medications

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Allergies – List any drug/food allergies

_____

_____

Any new surgeries/ diagnoses since your last visit? _____