Broadway Urgent Care **New and Return Patients** **Patient ID _____**

We do not see patients who are experiencing symptoms from a recent car accident.

complete the entire page.

SYMPTOMS: Circle any current symptoms below.

Constitutional: Chills, fever, weight gain/loss

Eyes: Crusty, discharge, dryness, foreign body, itching, pain, redness, watery, vision changes - Left, Right, Both

Ears: Discharge, pain, plugged up, ringing in ears - Left, Right, Both

Nose: Nasal Congestion, nasal drainage, sinus pain, sinus pressure, nose bleed

Throat: Mouth ulcers, neck stiffness, sore throat, swollen glands, toothache

Cardio/Heart: Chest Pain/discomfort, palpitations

Respiratory/Lungs: Cough, painful breathing, shortness of breath, tightness, wheezing

GI/Stomach: Abdominal pain, appetite change, blood in stool, blood in vomit, constipation, diarrhea, hemorrhoids, Nausea, vomiting

Urinary: Pain, frequency, urgency, blood in urine

Female: Breast lump, pelvic pain, heavy /irregular/missed/painful periods, vaginal discharge/itching

Male: Discharge, testicular mass, testicular pain

Muscles/Bones: Back pain, chest wall pain, joint pain, muscle aches, redness, sprain, swelling, weakness

Blood/Lymph: Unusual bleeding, unusual bruising, swollen lymph nodes

Neuro: Dizziness, headache, loss of consciousness, memory trouble, migraine, numbness, radiation of pain, seizures, tingling, weakness of extremities

Psych: Anxiety, depression, panic, sleeping difficulty, suicidal thoughts

Skin: Bite, bruising, hives, itch, lump, mass, rash, redness, laceration

Endocrine/Allergy: Allergic reaction, cold/heat intolerance, excessive hunger/thirst, fatigue, seasonal allergies

Other Symptoms:_____

PAST MEDICAL HISTORY

Anxiety/Depression	**Y/N**	**Diabetes**	**Y/N**
Asthma/COPD	**Y/N**	**Genetic Disease**	**Y/N**
Blood Clot/PE	**Y/N**	**Heart Disease**	**Y/N**
Cancer	**Y/N**	**High Blood Pressure**	**Y/N**

Other_____

SURGERY: ____Appendix ____Gallbladder

___Heart ____Tonsils ____Other

FAMILY MEDICAL HISTORY

Anxiety/Depression	**Y/N**	**Diabetes**	**Y/N**
Asthma/COPD	**Y/N**	**Genetic Disease**	**Y/N**
Blood Clot/PE	**Y/N**	**Heart Disease**	**Y/N**
Cancer	**Y/N**	**High Blood Pressure**	**Y/N**

Other_____

SOCIAL HISTORY

Smoker: __ Current ___Never ____Former

Street Drugs: ___Yes ___No

Alcohol user: ___Never

Drinks (#) _____per day ____per week ____per month

Employment Status:_____

Employer:_____

I have reviewed all of these symptoms and circled the ones that are current. There are no other current symptoms.

Signature:_____ **Date:**_____**Best Phone #:**_____

Page completed by: ____Patient _____Nurse/MA ___Family ____Caretaker ____Physician