



Full Legal Name (Please	e Print):								
Today's Date: Birthday:									
Email:									
Primary Care Physician: Other Physicians:									
The main reason I came	to the clinic toda	ay is:							
How did you hear abou	t The Walk-In Clir	nic at Grace? 🔲 A	dvertisement (	TV, Radio, Print) 🗌 Frienc	ls 🗌 Family				
🗌 My doctor outside c	of Grace Clinic:								
Medical History:	Please check any	v current significant m	nedical problems	3.					
Arthritis - Type, if know	vn:	High cholesterol	Cancer - Type, if	ack) 🛛 🗌 High blood Thyroid pro known:	blems				
Medications: The r	nedications I take	e are (including ove	r-the-counter, \	vitamins, herbs):					
Name:	Dose:	Frequency:		Dose:	Frequency:				
				own:					
Allergies: The allerg	ies or drug reacti	ons I have are:							
Drug or Substance:		Reaction		Comments:					
Surrior The surrive		naluda							
Surgeries: The surge Procedure	enes i nave naŭ n		Surgeon	Comments					
			Julyeon						
		/							
		/							





## **Review of Symptoms:**

Please check ALL current problems.

## GENERAL

F	е	V	er	

- Chills
- Sweats
- Weight Loss
- Weight Gain
- Other

## **EYES**

- Please circle right, left or both
- Vision changes (R/L)
- Eye injury (R/L)
- Eve irritation (R/L)
- Other

## EARS

- Please circle right, left or both
- Hearing loss (R/L)
- Earache (R/L)
- 0ther

## NOSE

Nasal co	ngestion
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- Sinus problems
- Nosebleed
- Other

## **MOUTH AND THROAT**

- Sores in mouth
- Difficulty swallowing
- Hoarseness
- Sore throat
- Other

## **CARDIOVASCULAR**

- Chest pain
- Shortness of breath
- Swelling of hands or feet Other

# RESPIRATORY

- Cough Difficulty sleeping
- Wheezing
- Other

#### GASTROINTESTINAL

- Nausea
- Vomiting
- Diarrhea
- Abdominal pain
- Bloody stools
- Other

#### **GENITOURINARY**

- □ Pain with urination
- Frequent urination
- Difficulty starting or maintaining urination
- Sexual difficulties
- Other

## **MUSCULOSKELETAL**

- Muscle cramps or aches
- Joint pain or swelling
- Back pain
- Other

## SKIN

- Rash
- **Itching**
- Suspicious lesions
- Other

I have answered the above questions to the best of my ability.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_/\_\_\_

## For office use only:

Send a copy of today's office visit to the patient's primary care physician.



Lumps of masses
Nipple discharge
Tenderness
Other

## **NEUROLOGICAL**

Headaches
Seizures

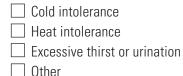
Weakness or numbness

	0	t	h	е	

# **PSYCHOLOGICAL**

Depression Anxiety Other

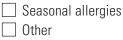
#### **ENDOCRINE**



## **HEMATOLOGICAL**

- Abnormal bruising
- Abnormal bleeding
- Other

## ALLERGY





Patient Care Form



# Family History:

Please check all				0. 1			
Family Member Father: Mother: Spouse: Brothers/Sisters: Children:					Heart Disease	Cancer (Type, if known)	
Social Histo	ory:						
Occupation:		-					
Habits:							
Y N Alcohol If yes, drinks/day			YN Cigars If yes, cigars/day		Y  N  Caffeine    If yes, servings/day		
Y N Cigarettes If yes, cigarettes/day			Y N Smokeless tobacco If yes, amount/day				
YN Street dru	gs - If yes, p	lease describe: .					
Immunizati	ions:	Date received	Comr	nents			
Tetanus: Hepatitis B: Flu Vaccine: Pneumonia:		// // //					
To be filled	d out by	WOMEN	only:				
		• To				ges? • Ab	ortions?

• How long have you been using this method? \_\_\_\_\_ • Date last mentrual period began (if applicable) \_\_\_/\_\_/\_\_\_