GRACE CLINIC®

Patient Care Form

Full Legal Name (Please Print): ______________________________

Today's Date: ____________________ Birthday: ____________________

Email: ______________________________

Primary Care Physician: ____________________ Other Physicians: ____________________

The main reason I came to the clinic today is: ______________________________

How did you hear about The Walk-In Clinic at Grace? ☐ Advertisement (TV, Radio, Print) ☐ Friends ☐ Family

☐ My doctor at Grace Clinic: ____________________ ☐ My doctor outside of Grace Clinic: ____________________

Please check all that apply below:

☐ I have changed my medications since my last visit to Grace Clinic.

☐ I have been hospitalized since my last visit to Grace Clinic.

☐ I have had surgery performed since my last visit to Grace Clinic.

☐ I have been diagnosed with new medical problems since my last visit to Grace Clinic.

* Please complete the Review of Systems sheet at every visit. *

Patient Care Form

Review of Symptoms:

Please check ALL current problems.

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Other

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

EARS
- Please circle right, left or both
- ☐ Hearing loss (R/L)
- ☐ Earache (R/L)
- ☐ Other

NOSE
- ☐ Nasal congestion
- ☐ 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

BREASTS
- ☐ Lumps or masses
- ☐ Nipple discharge
- ☐ Tenderness
- ☐ Other

NEUROLOGICAL
- ☐ Headaches
- ☐ Seizures
- ☐ Weakness or numbness
- ☐ Other

PSYCHOLOGICAL
- ☐ Depression
- ☐ Anxiety
- ☐ Other

ENDOCRINE
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst or urination
- ☐ Other

HEMATOLOGICAL
- ☐ Abnormal bruising
- ☐ Abnormal bleeding
- ☐ Other

ALLERGY
- ☐ Seasonal allergies
- ☐ 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.