SURFSIDE URGENT CARE

Health Questionnaire
Established Patient

To be completed by Surfside Personnel

Temp_____HR_____ BP_____/_____ RR_____

O2_____% WT_____ HT_____

VA OD_____/20 OS_____/20 OU_____/20

____ corrected ____ pin hole

Patient Name: _____ **Today's Date**_____

Reason you are being seen today: _____

When did your symptoms begin?: _____

SYMPTOMS: Please circle any symptoms you are having or have had recently.

CONSTITUTIONAL	APPETITE CHANGE	CHILLS	FATIGUE
	FEVER	SWEATS	WEIGHT LOSS
CARDIOVASCULAR	CHEST PAIN/PRESSURE	FAINTING	PALPITATIONS
NEUROLOGICAL	HEADACHE	LIGHT HEADEDNESS	NUMBNESS
	POOR BALANCE	TINGLING	WEAKNESS
PSYCHIATRIC	ANXIETY/NERVES	DEPRESSION	
LYMPHATIC	FREQUENT INFECTIONS	SWOLLEN GLANDS	
EYES	BLURRED VISION	CONTACT LENSES	DOUBLE VISION
	EYE DISCHARGE	EYE PAIN	EYE GLASSES
ENT	DIZZINESS	EAR PAIN	NASAL CONGESTION
	NOSE DISCHARGE	SNEEZING	SORE THROAT
RESPIRATORY	CONGESTION	COUGH	SHORT OF BREATH
	WHEEZING		
GASTROINTESTINAL	ABDOMINAL PAIN	DIARRHEA	NAUSEA
	RECTAL PROBLEM	BOWEL CHANGES	VOMITING
URINARY	DISCHARGE	FREQUENT URINATION	NIGHTTIME URINATION
	PAINFUL URINATION	SEXUAL DIFFICULTY	
MUSCULAR	JOINT PAIN	MUSCLE PAIN	SWELLING
SKIN	BRUISING	ITCHING	LACERATION
	RASH	REDNESS	SKIN SORES

[ ] None of the above [ ] Additional Problems: _____

Last Normal Menstral Period: _____ **Are You Pregnant?** [ ] yes [ ] No [ ] Unsure

_____

MEDICATIONS: [ ] **NONE** [ ] No Change From Prior Visit_____

_____

ALLERGIES: [ ] No Allergies [ ] No Change From Prior Visit _____

MEDICAL HISTORY: [ ] No Medical History [ ] No Change From Prior Visit
New Problems/Surgeries since last Visit: _____

SOCIAL HISTORY: [ ] No Change From Prior Visit

Tobacco Use: [} Never [} Quit: When _____; [ ] Current

Alcohol use: [ ] None [ ] Quit: When _____; [ ] Rare [ ] Occasional [ ] Daily

Recent Travel: [ ] No [ ] Yes: Where? _____

PREVENTATIVE (Vaccines): Tetanus: [ ] < 5 years [ ] > 5 years

[ ] Influenza/flu shot): Year: _____ [ ] Varicella/Chicken Pox