Name: ____
Last Name First Name DOB

Reason for your visit?: ____

Did the injury/ illness arise from work?: ___YES ___NO **Is the injuy MVA (automobile) related** ___YES ___NO

Primary Care Physician: ____
First Name Last Name

Preferred Pharmacy: ______________________ ______________________
Name Location

Do you have the following symptoms (Circle if yes)?:

Fever Sore Throat Rash Eye Pain Abdominal Pain Vertigo Chest Pain Cough Depression Back Pain

Do you have a FAMILY History of (Circle if yes):

Heart Disease Diabetes High Blood Pressure Cancer Asthma

Other: ____

Do you have a MEDICAL History of (Circle if yes):

Asthma Diabetes Hypothyroidism Kidney Disease Cancer Seizures Psychiatric Hypertension

High Cholesterol Congestive Heart Failure Heart Attack Stroke

Other: ____

Medications?		**Allergies to Medications?**	**Surgeries?**
NONE (circle if applies)	4	NONE (circle if applies)	NONE (circle if applies)
1	5	1	1
2	6	2	2
3	7	3	3

Circle what applies:

Drink Alcohol?	No	Socially	Daily	Other
Do you Smoke?	YES / NO			
Drug Use?	YES / NO			

Please provide the following:

Height: __________ **LMP:** __________
Weight: __________ **Pregnant?** YES / NO
Due Date: __________

Consent for services and/or disclosure of Protected Health Information:
I hereby request and consent to medical evaluations and treatment provided to me by the staff at Accel Care.

X ____ Date: __________
Signature

DO NOT WRITE BELOW THIS LINE

****

Chief Complaint: ____

____

____

____

Vital Signs

Time			
Temp			
*HR			
*RR			
*BP			
*Sats			
Pain Level			

Weight __________
Height __________
[ ] Actual [ ] Stated

LMP: __________
Pregnant? __________
Due Date: __________

Immunizations:

Ped Immunizations: ______________________ **Pneumococcal:** ______________________

Influenza: ______________________ **Tetanus:** [ ] - than 5 years [ ] + than 5 years [ ] unknown

Notes: ____
Above information has been verified w/patient.

X ____
Nurses Signature Time