DELTA URGENT CARE
Walk-in Clinic and Occupational Medicine

Have you been a patient here before? **YES** or **NO**
Is this a result of a **work accident**? **YES** or **NO**
Is this a result of a **motor vehicle accident**? **YES** or **NO**

Staff Only
Date: _____
INS: _____
MR#: _____
Room #: _____
Copay: $_____

****NOTIFY THE STAFF IMMEDIATELY IF YOU FEEL YOU HAVE CHEST PAIN, SHORTNESS OF BREATH, SEVERE ABDOMINAL PAIN, HEAD INJURY or the WORST HEADACHE OF YOUR LIFE Before Continuing.*****

Name_____ **DOB**_____ **Age**_____

Reason for visit? _____ **When did symptoms start?** _____

Medication Allergies _____ **Pharmacy (please specify)** _____

Current Medications_____

Current Symptoms (please check all that apply)

☐ Body Aches	☐ Cough	☐ Rash	☐ Frequent Urination
☐ Fever/Chills	☐ Shortness of Breath	☐ Abscess	☐ Burning with Urination
☐ Earache	☐ Wheezing	☐ Laceration	☐ Abdominal Pain
☐ Eye Problem	☐ Chest Pain	☐ Headache	☐ Diarrhea
☐ Sinus	☐ Back/Neck Pain	☐ Dizziness	☐ Nausea/Vomiting
☐ Sore Throat	☐ Joint Pain	☐ STD Exposure	☐ Tooth Pain
☐ Covid-19 (+) Exposure	☐ Loss of taste/smell	☐ Pregnant Due Date: _____	☐ Other_____

Past Medical History (please check all that apply)

☐ Acid Reflux/GERD	☐ Diabetes	☐ Seizures
☐ Anemia	☐ Heart Attack/CAD	☐ Skin Disorder
☐ ADD/ADHD	☐ High Cholesterol	☐ Stroke/TIA
☐ Anxiety/Depression	☐ High Blood Pressure	☐ Thyroid Disease
☐ Asthma/COPD	☐ Kidney Disease	☐ Other
☐ Cancer _____	☐ Migraines	☐ **No Past Medical History**

Past Surgeries (please check all that apply)

☐ Appendectomy	☐ Tubes in Ears	☐ Tonsillectomy/Adenoidectomy
☐ Cardiac/Stents #_____	☐ Hernia Repair	☐ Circumcision
☐ C-Section #_____	☐ Hysterectomy	☐ Tubal ligation/Ablation
☐ Gall Bladder	☐ Thyroidectomy	☐ Other
☐ DNC	☐ Back/Neck	☐ **No Previous Surgeries**

Social History (please circle all that apply)

Smoker: Yes or No #PPD_____	Alcohol: Yes or No	Recreational Drug Use: Yes or No

Family Medical History of: Father_____**Mother**_____
Last Menstrual Cycle _____ **Birth Control** ☐**Yes** ☐ **No** **Tetanus Up To Date:** ☐**Yes** ☐ **No** **Year** _____

Vital Signs (Staff Only)

Temp	**Pulse**	**B/P L / R**	**Respirations**
O2 Stat	**Pain level 0-10 _____**	**Height _____**	**Weight _____LBS or KG**