WakeMed Urgent Care Patient Intake Form

Patient Name_____ Date of Birth _____ Primary Doctor_____

Pharmacy for Today's Rx _____Reason for Visit_____

Do you have a history of asthma? ❑ yes ❑ no Is it controlled? ❑ yes ❑ no

Do you use tobacco? ❑ yes ❑ never ❑ quit date: _____
Packs/Day _____ Years Smoked _____ Smokeless Tobacco Use _____

Do you have a history of high blood pressure? ❑ yes ❑ no

Immunizations
Childhood Immunizations up to date? ❑ yes ❑ no

Circle One - TDap/Tetanus ❑ yes ❑ no Within the past **5 yrs?** ❑ yes ❑ no

Flu Shot - ❑ yes ❑ no Month & Year Given _____

Have you been evaluated for similar condition? Yes / No
If yes, where?_____

Any change in medical or surgical past history from last visit?
_____
_____

Drug Allergies/Reaction:/ Date:

1. _____	3. _____	5. _____
2. _____	4. _____	6. _____

Current Medications/Reason for taking/Dosage Times per day

1. _____	3. _____	5. _____
2. _____	4. _____	6. _____

Clinical Staff Only

Time _____

Temp: _____ **Source:** Oral Tympanic Rectal Axillary

Heart Rate: _____ **Location:** Right Left Apical Carotid Brachial Radial

BP: _____ **Location:** Right Left **Method:** Automatic Manual **Position:** Sitting Standing Supine

Respirations: _____

Height: _____ **Weight:** _____ **Pulse Ox:** _____

LMP:_____

Notes:_____

_____