FASTER CARE PATIENT INFORMATION

1. Last Name_____First Name_____
2. Address:_____
3. City, State, Zip:_____
4. Phone:_____DOB:_____Age:_____
5. Weight:_____ Height:_____
6. Who is your regular doctor?_____
7. What pharmacy do you want to use today?_____
   This will be the pharmacy you use today. NO EXCEPTIONS

8. **Will you need a work or school note?** Circle: **WORK SCHOOL NONE**

9. What is your chief complaint today and when did it start:

_____

10. List symptoms:_____

_____

11.Do you have any medical conditions? **Circle: YES or NO** If yes, please list:

_____

_____

_____

12. Are you allergic to any medications? **Circle: YES or NO** If yes please list:_____

_____

13. Do you take any medications? **Circle: YES or NO** If yes, please list names of each:

_____

_____

_____

14. Have you ever had any surgeries: **Circle: YES or NO** If yes, please list:

_____

_____

15. Have you ever been hospitalized? **Circle: YES or NO** If yes, please list reason:

_____

_____

_____

16. Date of Last Tetanus:_____

If applicable, are your child's immunizations up to date? **YES or NO**

Office Use: Time:
Ins:
Pre-auth:
Y or N

BP: BP:

P: P:

R: R:

T: T:

O2: O2:

OFFICE USE, LEAVE BLANK.

17. **Women:** Date of last period?_____ Are you pregnant or nursing? **YES or NO**_____

18. **Please list hereditary medical conditions of people listed regardless if alive or deceased:**
Father: [_] alive [_] deceased_____

Mother: [_] alive [_] deceased_____

Siblings: [_]alive [_] deceased_____

Children: [_] alive [_] deceased_____

19. Do you have someone to make medical decisions on your behalf should you become unable to make the decisions for yourself? **YES or NO** Name:_____Phone:_____
Address:_____

20. Do you □ smoke □ use smokeless tobacco □ vape □ none

If yes, how much/how often per day?_____

-Use illegal drugs/substances? **YES or NO** If yes, what and how much? _____

-Do you drink alcohol? **YES or NO** If yes, please answer the following:
***How often did you drink alcohol this past year?

[ ]Never [ ]Monthly or less [ ] 2-4 a month [ ]2-3 a week

***How many drinks did you have on a typical day when you were drinking?

[ ]1-2 [ ]3-4 [ ]5-6 [ ]7-8 [ ]10 or more

***How often did you have 6 or more drinks on one occasion in the past year?

[ ]Never [ ]less than monthly [ ]Monthly [ ]Weekly [ ]Daily or almost daily

INSURANCE AND ACCIDENT QUESTIONNAIRE

Patient Name:_____

Date of Service:_____

1. **Do you have any health coverage other than the cards presented? YES or NO**
   ****If you indicated YES, inform front desk. We need information about possible other health coverage in order to process your claims correctly.**

2. **Is today's visit a result of an injury? YES or NO**
   **** If Yes, check one of the following: ___Auto/Motorcycle Accident ___Work Related ____Other**

   Describe the injury including how and where it happened:_____
   _____

   Signature: _____ Date: _____ Telephone: _____