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