Rapidcare Medical Information Form

Name ____ DOB _____/_____/________

Reason for today's visit ____

____

____

Are you having pain ? **Yes** **No** Please Rate 0 1 2 3 4 5 6 7 8 9 10

0	1	2	3	4	5
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

Past Medical History: Please tell us about your past medical history. Any high blood pressure, pneumonia, heart problems, lung problems, asthma etc.

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Past Surgical History: ____

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Family History: Parents alive? Mother Yes No Father Yes No

Any known illness in parents? ____

Brothers, sisters or other first degree relatives with known inheritable illness? ___________________________

____

Social History: Your occupation ____

Smoker: Yes No Quit When ______________ Cigarettes Cigars Pipe Chewing Tobacco Snuff Vape Other Tobacco Marijuana

Alcohol: Never Occasional/social Weekly Daily

Married: Divorced Widowed

Date	*Room*	*Time*	*MA* *1 of 3*

Medications Please list all the medications you are taking. Include over the counter meds, herbs and vitamins. Please include the Mg size and dose. Include herbals, supplements and over the counter meds

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____

Allergies ____

____
____

**************************Do not write below this line****************************

Patient derived information amended and reviewed by physician _________________________

Temp ______ Pulse ______ Resp ______ BP _______/______ Sat ______ %RA

Height ______ Weight ______

HPI ____

____
____
____
____

General	*Fever*	*Chills*	*Weakness*	*Weight loss*			
Eyes	*Injury*	*Pain*	*Redness*	*Discharge*	*Vision loss*		
ENT	*Ear pain*	*Hearing loss*	*Discharge*	*Nasal cong*	*Sinus pain/pressure*	*Sore throat*	*Voice loss*
Resp	*Dyspnea*	*Cough*	*Dry*	*Productive*	*Wheeze*	*Pleuritic pain*	
Cardiac	*Chest pain*	*DOE*	*Orthopnea*	*Palpitations*			
GI	*Pain*	*Nausea*	*Vomiting*	*Diarrhea*	*Constipation*	*Reflux*	
GU	*Dysuria*	*Frequency*	*Hematuria*	*Incontinence*	*Flank pain*		
MS	*Neck pain*	*Back pain*	*Joint pain*	*Recent trauma*			
Neuro	*Headache*	*Syncope*	*Focal weakness*	*Vertigo*	*Seizure*	*Paresthesia*	
Skin	*Rash*	*Lesions*	*Bites*				
Endocrine	*Swollen glands*	*Polyuria*	*Polydipsia*	*Fatigue*	*Hair loss*		
Psych	*Anxiety*	*Depression*	*Mood swings*	*Suicidal*			

The remainder of ROS are reviewed and negative ___________________