EMURGENT CARE ENCOUNTER **DOS**____________

PT ACCT: ______________ EST NP F/U SP MVA WC DS DOT EMT NV

NAME____**DOB** ____/_____/____ **AGE** ____________

ADDRESS ____________________________**CITY** ________________**ST**________**ZIP**__________

PHONE __________________ **EMAIL**____

PRIMARY CARE _________________________ **PHARMACY FOR TODAY**_______________

REASON FOR VISIT ____

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MEDICATIONS: ____

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MEDICATION ALLERGIES: ____

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Adult Social History:
Do you Smoke or Vape? Yes No
Any History of Second Hand Smoke? Yes No
Do you Consume Alcohol? Yes No
Use of Recreational Drugs? Yes No

Child Social History:
Live With Parents? Yes No
Exposed to Smoke? Yes No
Pets in Home? Yes No

Diagnosed Medical Conditions:

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Patient/Parent Signature ____________________________________ **Date** ______________

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FOR OFFICE USE ONLY

BP __________ **Osat** __________ **P** __________ **R** __________ **T** __________oral/ ax

WT __________ **HT** _________ **LMP**_________

Provider Orders: ____Rapid Strep ____UA Dipstick ______Hcg X-ray _________________
____Throat Culture ____UA Culture ____Wound Culture ____Rapid Flu ____Blood Draw _____Neb
Other ____________ IM Inj ______________mg_______

Needs Referral to ________________________________
Provider Signature _________________________________**Date** ______________

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