HH Walk-in Clinic

HH Walk-in Clinic is an urgent care clinic*, not* an emergency room. Patients with emergent needs should proceed *immediately* to the Emergency Department.

The following conditions require a higher level of care that this clinic is equipped to provide. If you are experiencing *any* of these listed symptoms, please notify the receptionist *immediately*.

Chest Pain with Shortness of Breath

Shortness of Breath

Stroke Symptoms

Traumatic Head Injury

Motor Vehicle Accidents

Prenatal or OB care

Assault

Chronic Pain (including back pain and headaches)

Workman's Comp

Date: _____ Time: _____ **New Patient or Returning Patient**

Patient Name: _____

Date of Birth: _____ Social Security Number: _____

Marital Status: M S D W Gender: Male or Female Employer:_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____ _____

Email: _____ Preferred Contact Method: cell home work

Emergency Contact: _____ Phone Number: _____Relation:_____

Insurance: YES or NO (Co-pays are required at check-in. If you do not have insurance and you are a new patient, a minimum fee of $114.40 will be due. If you are a returning patient, a minimum fee of $75.25 will be due. Your visit may result in a charge in excess of this amount.)

What brings you to the office today? _____

If Insurance Cardholder is not you: Relationship to cardholder: _____ Cardholder DOB: _____

Have you ever been seen at a HH Physician Office Before (Not HH Main/ER)? Yes or No

HH Walk-in Clinic

DATE: _____

NAME: _____

DATE OF BIRTH: _____

REASON FOR VISIT: _____

PLEASE CIRCLE PROBLEMS YOU ARE HAVING TODAY:

GENERAL:	FEVER CHILLS FATIGUE RECENT WEIGHT LOSS
EYES:	DOUBLE VISION EYE IRRITATION BLURRED VISION EYE PAIN EYE DISCHARGE LIGHT SENSITIVITY
EARS/NOSE/THROAT:	RINGING EARS EAR DISCHARGE EARACHE HEARING LOSS CONGESTION DIFFICULTY SWALLOWING HOARSENESS NOSE BLEEDS SORE THROAT
CARDIOVASCULAR:	CHEST PAIN PALPITATIONS SHORTNESS OF BREATH WALKING SHORTNESS OF BREATH WHEN LYING DOWN SWELLING OF FEET OR ANKLES LIGHTHEADEDNESS LEG CRAMPS
RESPIRATORY:	COUGH SHORTNESS OF BREATH COUGHING UP BLOOD CHEST DISCOMFORT WHEEZING
GASTROINTESTINAL:	LOSS OF APPETITE CHANGE IN BOWEL MOVEMENTS NAUSEA VOMITING DIARRHEA PAINFUL BOWEL MOVEMENTS CONSTIPATION BLOOD IN STOOL DARK, TARRY STOOL
GENITOURINARY:	FREQUENT URINATION BURNING OR PAINFUL URINATION BLOOD IN URINE INCONTINENCE KIDNEY PAIN
MUSCULOSKELETAL:	JOINT PAIN JOINT STIFFNESS JOINT SWELLING MUSCLE WEAKNESS LOSS OF STRENGTH MUSCLE CRAMPS
DERMATOLOGIC:	RASH ITCHING CHANGE IN SKIN COLOR
NEUROLOGIC:	FREQUENT HEADACHES NUMBNESS TINGLING MEMORY LOSS CONFUSION
PSYCHIATRIC:	DEPRESSION INSOMNIA ANXIETY
ENDOCRINE:	HORMONE PROBLEM EXCESSIVE THIRST EXCESSIVE URINATION HEAT INTOLERANCE COLD INTOLERANCE
HEMATOLOGICAL:	ABNORMAL BRUISING PROLONGED BLEEDING
IMMUNOLOGIC:	SEASONAL ALLERGIES HIVES PERSISTANT INFECITONS
	PERSISTENT INFECTIONS

PHARMACY NAME: _____ **PHARMACY LOCATION:** _____

PAIN: Y or N **LOCATION:** _____ **INTENSITY (1-10):** _____

PLEASE FILL OUT THE FOLLOWING INFORMATION IF WE NEED TO UPDATE MEDICATION OR ALLERGIES:

ALLERGIC TO: **REACTION:** ☐ **NO ALLERGIES**

_____ _____

_____ _____

_____ _____

CURRENT MEDICATIONS: ☐ REFER TO LIST ☐ REFER TO BOTTLES ☐ **NO MEDICATIONS**

PLEASE INCLUDE THE DOSE AND HOW OFTEN YOU TAKE THE MEDICATION (NO NEED TO LIST BELOW IF YOU BROUGHT A LIST OR BOTTLES)

NAME	DOSAGE	HOW MANY TIMES PER DAY	AS NEEDED (PRN)