Valley Urgent Care & Occupational Medicine
119 University Blvd. Harrisonburg, VA 22801
PHONE: 540-434-5709 FAX: 540-434-5710

MEDICAL HISTORY
REVIEW OF SYSTEM FORM

DATE:_____NAME:_____DATE OF BIRTH_____
____MARRIED ____SINGLE ____DIVORCED ____WIDOWED; OCCUPATION:_____
NO.OF CHILDREN:____TOBACCO USE: YES/NO HOW MUCH?_____/DAY HOW LONG? DATE QUIT_____
ALCOHOL USE: HOW MUCH PER DAY?_____CAFFEINE (COFFEE,TEA,COLAS) PER DAY_____

PAST ILLNESSES OF YOURSELF AND FAMILY:

YOU/YOUR FAMILY	YOU/YOUR FAMILY	YOU/YOUR FAMILY
☐ ☐ ALCOHOLISM	☐ ☐ HIGH BLOOD PRESSURE	☐ ☐ STROKE
☐ ☐ ANEMIA	☐ ☐ KIDNEY DISEASE	☐ ☐ SUICIDE ATTEMPT
☐ ☐ ASTHMA	☐ ☐ LIVER DISEASE	☐ ☐ THYROID DISEASE
☐ ☐ CANCER/TUMOR	☐ ☐ HEPATITIS	☐ ☐ TUBERCULOSIS, TB
☐ ☐ DIABETES	☐ ☐ LUNG DISEASE	☐ ☐ ULCER IN GI TRACT
☐ ☐ DRUG ABUSE	☐ ☐ MENTAL ILLNESS	☐ ☐ VENEREAL DISEASE
☐ ☐ DEPRESSION	☐ ☐ OSTEOARTHRITIS	☐ ☐ HIGH CHOLESTEROL
☐ ☐ EPILEPSY/SEIZURES	☐ ☐ OSTEOPOROSIS	☐ ☐ HIV/IMMUNE DX
☐ ☐ GLAUCOMA	☐ ☐ PHLEBITIS	☐ ☐ OTHER_____
☐ ☐ HEART DISEASE	☐ ☐ RHEUMATIC ARTHRITIS	

PAST SURGICAL HISTORY: (PLEASE INCLUDE DATES)
_____
_____
_____
_____

REVIEW OF SYSTEMS-PLEASE CHECK EACH ITEM "YES" OR "NO" AS THEY RELATE TO YOUR HEALTH:

CONSTITUTIONAL:	Yes	No
Weight Loss	☐	☐
Fatigue	☐	☐
Fever	☐	☐
EYES:		
Glasses/Contacts	☐	☐
Eye Pain	☐	☐
Double Vision	☐	☐
Cataracts	☐	☐
EAR,NOSE,THROAT:		
Difficulty Hearing	☐	☐
Ringing in Ears	☐	☐
Vertigo	☐	☐
Sinus Trouble	☐	☐
Nasal Stuffiness	☐	☐
Frequent Sore Throat	☐	☐
CARDIOVASCULAR:		
Murmur	☐	☐
Chest Pain	☐	☐
Palpitations	☐	☐
Dizziness	☐	☐
Fainting Spells	☐	☐
Shortness of Breath	☐	☐
Difficulty lying Flat	☐	☐
Swelling Ankles	☐	☐
ENDOCRINE:		
Loss of Hair	☐	☐
Heat/Cold Intolerance	☐	☐

RESPIRATORY	Yes	No
Cough	☐	☐
Coughing Blood	☐	☐
Wheezing	☐	☐
Chills	☐	☐
GASTROINTESTINAL:		
Heartburn/Reflux	☐	☐
Nausea/Vomiting	☐	☐
Constipation	☐	☐
Change in BMs	☐	☐
Diarrhea	☐	☐
Jaundice	☐	☐
Abdominal Pain	☐	☐
Black or Bloody BM	☐	☐
GENITOURINARY:		
Burning/Frequency	☐	☐
Nighttime	☐	☐
Blood in Urine	☐	☐
Erectile Dysfunction	☐	☐
Abnormal Discharge	☐	☐
Bladder Leakage	☐	☐
ALLERGIC/IMMUNOLOGIC:		
Hives/Eczema	☐	☐
Hay Fever	☐	☐
PSYCHIATRIC:		
Anxiety/Depression	☐	☐
Mood Swings	☐	☐
Difficult Sleeping	☐	☐

HEMATOLOGY/LYMPH	Yes	No
Easy Bruising	☐	☐
Gums Bleed Easily	☐	☐
Enlarged Glands	☐	☐
MUSCULOSKELETAL:		
Joint Pain/Swelling	☐	☐
Stiffness	☐	☐
Muscle Pain	☐	☐
Back Pain	☐	☐
SKIN:		
Rash/Sores	☐	☐
Lesions	☐	☐
Itching/Burning	☐	☐
NEUROLOGICAL:		
Loss of Strength	☐	☐
Numbness	☐	☐
Headaches	☐	☐
Tremors	☐	☐
Memory Loss	☐	☐

FEMALES ONLY:
Date Last Mammogram_____
Normal_____Abnormal_____
Date last PAP_____
Normal_____Abnormal_____
Age Onset Periods_____
Age Onset Menopause_____
Periods Regular? Yes_____No____
Number Pregnancies_____

SIGNATURE OF PERSON COMPLETING FORM:_____ DATE: _____

REVIEWING PHYSICIAN SIGNATURE:_____ DATE: _____

ALL PATIENTS PLEASE COMPLETE NEXT PAGE

NEW PATIENT- PLEASE COMPLETE THE FOLLOWING

Name:_____Date:_____

CURRENT MEDICATIONS: INCLUDE BIRTH CONTROL PILLS,VITAMINS, AND SUPPLIMENTS

MEDICINE NAME	HOW TAKEN?	WHO PRESCRIBES?	NEED RX
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO
			YES/NO

PREFERRED PHARMACY:_____LOCATION:_____

PREVIOUS HEALTH CARE PROVIDERS IN PAST FIVE YEARS:

NAME	CITY/STATE	PROBLEM CARED FOR:	STILL SEEING?
			YES / NO
			YES / NO
			YES / NO
			YES / NO

ALLERGIC AND ADVERSE REACTIONS TO MEDICATIONS

NAME OF MEDICATION:	ADVERSE REACTION

ADDITIONAL INFORMATION:

LAST MAMMOGRAM?_____ WHERE?_____LAST PAP?_____GYN?_____

LAST COLONOSCOPY?_____NORMAL?_____DR?_____REPEAT DATE?_____

APPROXIMATE DATE OF LAST BLOODWORK?_____RECTAL EXAM?_____

VACCINE DATES:

TETANUS?_____PNEUMONIA?_____FLU?_____HEPATITIS B SERIES?_____

TRIAGE FORM

VALLEY URGENT CARE &OCCUPATIONAL MEDICINE

Patient Name / *Nombre* (PRINT)_____ Date/*Fecha*_____

1. Are you having difficulty breathing?

   ¿Tiene dificultad para respirar? __Yes/Si __NO

2. Do you have chest pain?

   ¿Tiene dolor en el pecho? __Yes/Si __NO

3. Did you lose consciousness or have a seizure?

   ¿Perdió el conocimiento o sufrir convulsiones? __Yes/Si __NO

4. Are you dizzy or nauseated?

   ¿Está usted mareado o con náuseas? __Yes/Si __NO

5. Are you having an allergic reaction?

   ¿Está teniendo una reacción alérgica? __Yes/Si __NO

6. Are you bleeding profusely?

   ¿Estás sangrando profusamente? __Yes/Si __NO

7. Do you have severe (doubling over) abdominal pain?

   ¿Tiene grave (doblándose) dolor abdominal? __Yes/Si __NO

8. Do you have blurred vision?

   No tiene visión borrosa? __Yes/Si __NO

9. Is the patient to be treated under the age of 16?

   ¿Es el paciente tratado aunque sea menor de la edad de 16 años? __Yes/Si __NO

10. I need to be seen for the following reason:

    Tengo que ver al medico por las siguientes razones:

    _____

    _____

SIGNATURE (*FIRMA*): _____ DATE (*FECHA*): _____

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□ NEW PATIENT
□ ESTABLISHED PATIENT

□ Work Related □ Insurance □ Self Pay

PATIENT INFORMATION

Last Name _____ First Name _____ M _____

Date of Birth ___/___/___ Age _____ Sex □ M □ F Social Security # ___—___—_____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone (___) ___—_____ Mobile Phone (___) ___—_____ Preferred □ Home □ Mobile

Email _____ Race _____ Ethnicity _____ Preferred Language _____

Primary Care Physician _____ Phone (___) ___—_____

In case of Emergency (Name, Phone, Relation) _____

Patient Employed By _____ Work Phone (___) ___—_____

How did you hear about us? □ Billboard □ Drive By □ Email □ Facebook/Twitter □ Insurance □ Mailer
□ Media □ Military □ School □ Webpage □ Word of Mouth

PARENT/GUARANTOR INFORMATION

Last Name _____ First Name _____ M _____

Date of Birth ___/___/___ Age _____ Sex □ M □ F Social Security # ___—___—_____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone (___) ___—_____ Mobile Phone (___) ___—_____ Preferred □ Home □ Mobile

Relation to Patient □ Parent □ Guardian □ Spouse □ Employer

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:
Authorization of Treatment: The administration and cost of all medical and surgical procedures, x-ray, and medication for myself and for my dependents.
GUARANTEE OF PAYMENT:

_____**INITIAL** □ SELF PAY – I elect to pay for all services rendered in full today. I understand that my insurance will NOT be billed by Valley Urgent Care (VUC).

_____**INITIAL** □ INSURANCE – Assignment of Benefits: I authorize payment directly to Valley Urgent Care (VUC) for all benefits otherwise payable to me. I also acknowledge that VUC will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance today based on the best available information of my current policy and VUCs current contract with my insurance carrier. I understand this is only an estimate and after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. While VUC makes every effort to verify my correct insurance information prior to leaving, I understand VUC cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred. I also acknowledge I am responsible for any and all attorney fees, court costs, or any other costs associated with the collection of the unpaid balance.

Release of Medical Records: I authorize Valley Urgent Care (VUC) to release verbally, electronically, and/or in writing confidential medical information to any person or entity including my insurance carrier, employer (if treatment is related to employment), immediate family member (s), and/or other healthcare provider (s) for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures. I understand that should I choose not to release my medical record to a specific entity and/or person (s) I must specifically state so in writing to be kept in my medical record.

Receipt of Privacy Practices: By signing this consent form I acknowledge that a copy of the Notice of Privacy Practices of Valley Urgent Care is available to me upon request I understand that a copy of this consent form may be used with the same effectiveness as the original.

Patient Signature _____ Date _____
Responsible Party_____ Date _____