FASTER CARE PATIENT INFORMATION

1. Last Name_____First Name_____
2. Address:_____
3. City, State, Zip:_____
4. Home Phone:_____Cell:_____ Work: _____
5. DOB:_____Age:_____ 6. Weight:_____ Height:_____
7. Who is your regular doctor?_____
8. What pharmacy do you want to use today?_____
   This will be the pharmacy you use today. NO EXCEPTIONS
9. **Will you need a work or school note? WORK SCHOOL NONE**

10. What is your chief complaint today and when did it start:

_____

11. List symptoms:_____

_____

12.Do you have any medical conditions? YES NO If yes, you must list:

_____

_____

_____

13. Are you allergic to any medications? YES NO If yes, you must list list:_____

_____

14. Do you take any medications? YES NO If yes, you must list names of each: _____

_____

_____

15. Have you ever had any surgeries: YES NO If yes, you must list:

_____

_____

16. Have you ever been hospitalized? YES NO If yes, you must list reason:

_____

_____

_____

17. Date of Last Tetanus:_____

If applicable, are your child's immunizations up to date? **YES or NO**

18. **Women:** Date of last period?_____

Are you pregnant or nursing? **YES NO**

Office Use: Time:
Ins:
Pre-auth:
Y or N

BP: BP:

P: P:

R: R:

T: T:

O2: O2:

OFFICE USE, LEAVE BLANK.

19. **List hereditary medical conditions of people listed regardless if alive or deceased:**

Information unknown due to adoption [_]

Father: [_] alive [_] deceased: List hereditary conditions: _____**OR** No hereditary conditions[_]

Mother: [_] alive [_] deceased List hereditary conditions: _____**OR** No hereditary conditions[_]

Siblings: [_]alive [_] deceased List hereditary conditions: _____**OR** No hereditary conditions[_]

Children: [_] alive [_] deceased List hereditary conditions: _____**OR** No hereditary conditions[_]

20. 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:_____

21. Use illegal drugs/substances? **YES or NO** If yes, what and how much? _____

22. 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**

23. Do you use Nicotine and/or Tobacco Procucts **Yes or No** If yes, which product

[ ]**Cigarettes** [ ]**Cigars** [ ]**Chewing Tobacco** [ ]**Dip/Snuff** [ ]**Hookah** [ ]**Patches** [ ]**Pipe** [ ]**Vape**

List if other:_____

24. Are you a current or former smoker? **Current Smoker** **Former Smoker (Skip to part B)**

A) If current smoker, answer the following questions

***How often do you smoke cigarettes? [ ] **Every day** [ ] **Some days, but not every day**

***How many cigarettes a day do you smoke? [ ] **5 or less** [ ] **6-10** [ ] **11-20** [ ] **21-30** [ ] **31 or more**

***How soon after you wake up do you smoke your first cigarette?

[ ] **within 5 min** [ ] **6-30 min** [ ] **31-60 min** [ ] **+60 min**

*** Are you interested in quiting? [ ] **Ready to quit** [ ] **Thinking about quitting** [ ] **Not ready to quit**

B) If former smoker, answer the following question

***Are you a….

[ ]**Current non-smoker** [ ]**Ex-cigar smoker** [ ]**Ex-cigarette smoker** [ ]**Ex-pipe smoker** [ ]**Ex-user of moist powdered tobacco**