**Acct #: _____ Date of Service: _____ Room #: _____**

**New PT _____ Established PT _____**

**Name**: _____ **DOB**: _____ **Age**: _____

**If female, Date of last menstrual period**: _____

**Primary Care Physician**: _____ **Preferred Pharmacy:** _____

**Allergies**: _____

**Tobacco User**: Y N **If yes, Smoker**: ____ Packs/Day:_____ **Smokeless Tobacco**: _____

**Family History:**

**Please list family member and check all that apply**

| Family Member | Diabetes | High Blood Pressure | Heart Disease | Cancer |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Reason for Todays Visit:**

- ☐ Chills
- ☐ Sinus Congestion
- ☐ Sinus Pain
- ☐ Nasal Congestion
- ☐ Upper Respiratory Symptoms
- ☐ Chest Congestion
- ☐ Cough
- ☐ Wheezing
- ☐ Sore Throat
- ☐ Diarrhea
- ☐ Fever
- ☐ Nausea
- ☐ Vomiting
- ☐ Flu Like Symptoms
- ☐ Abdominal Pain
- ☐ Urinary Tract Symptoms
- ☐ Back Pain
- ☐ Eye Irritation
- ☐ Headache/Migraine
- ☐ Ear Pain
- ☐ Rash
- ☐ Sprain/Strain
- ☐ Laceration
- ☐ Injury DATE: _____
- ☐ Other:_____

_____

_____

Treatments Tried:_____

Did they help?: _____

For Office Use Only:

| Injection | Lot # | Expiration | DR | Nurse | Dr's Orders/Amount |
|---|---|---|---|---|---|
| Decadron | | | | | |
| Rocephin | | | | | |
| Toradol | | | | | |
| Zofran | | | | | |
| Phenergan | | | | | |
| TDAP | | | | | |
| B12 | | | | | |
| Celestone | | | | | |

HT: _____ WT: _____ B/P: _____/_____

Temp: _____ $SPO^2$: _____% HR: _____