Palm Bay Urgent Care Triage

Today's Date_____

Patient Name: _____

Reason for visit: _____

Date Symptoms Began: _____

Pain Scale (from 0-10 with 10 being the worst): _____

Last Tetanus shot: _____

Medication Allergies: Yes or No (If Yes, please list):

_____

Current Medications: Yes or No (If Yes, please list):

_____

Female Patients pregnant: Yes /No **Last menstrual cycle:** _____**Breast Feeding:** Yes /no

Past Medical History: None, Heart Disease, Diabetes, High Blood Pressure, Stroke, Cancer

Other_____

Family History: None, Heart Disease, Diabetes, High Blood Pressure, Stroke, Cancer

Other_____

Past Surgery: None, Appendix, Gallbladder, Heart, Hysterectomy, C-section

Other_____

Do you use Tobacco? Yes/No/Former smoker quit: _____

Do you drink Alcohol? Yes/ No/ Occasionally /Daily

Do you use illicit drugs? Yes/No
If yes list: _____

Employment: Employed: Occupation_____ /unemployed /Homemaker/student/retired /other

Relationship status: Married / Single/ Divorced / Widowed / lives with partner

Living Situation: alone / with family / Roommate /Assisted living /Nursing home /Homeless

Activities of Daily Living: Requires assistance with _____

Diet: healthy / unhealthy /admits to eating disorder

Caffeine: none /occasional / daily coffee_____ / Daily soda and tea _____

Exercise: none/ sporadic / daily

Sleep: no sleep problem / occasional sleep problem / has sleeping problems