

## Welcome to Ozark Urgent Care

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_ **Have been here before?** Yes \_\_\_\_\_ No \_\_\_\_\_  
**Telephone #:** \_\_\_\_\_ **If no, how did you hear about us?** \_\_\_\_\_

**Yes, I have read the HIPAA Privacy Statement on the clipboard.**

Reason for Visit: \_\_\_\_\_

Have you seen a Doctor recently?  Yes  No When? \_\_\_\_\_

Other Medical History? \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Allergic to any medicine?**  Yes  No If yes, explain: \_\_\_\_\_

Immunizations Up to Date?  Yes  No **Do you smoke?**  Yes  No

Would you be interested in our monthly E-Newsletter about health issues and clinic specials?  Yes  No

**Email:** \_\_\_\_\_

**Fee:** \_\_\_\_\_ **Payment Method:** \_\_\_\_\_

Resps.	Temp.	Pulse Ox	B/P	Pulse	Weight	Height

ROS: *as above o/w negative*  
HPI:

PE: Visual Exam: R \_\_\_\_/\_\_\_\_ L \_\_\_\_/\_\_\_\_, corrected \_\_\_\_ uncorrected \_\_\_\_

✓ = Normal X = Abnormal

HEENT \_\_\_\_\_  
 NECK \_\_\_\_\_  
 LUNGS \_\_\_\_\_  
 HEART \_\_\_\_\_  
 ABD \_\_\_\_\_  
 HERNIA \_\_\_\_\_  
 EXT \_\_\_\_\_  
 NEURO \_\_\_\_\_  
 GU \_\_\_\_\_  
 SKIN \_\_\_\_\_

Lab	X-Ray	Injections /Immunizations

A/P:

f/u if worse; no improvement in 2-3 days or if not better in one week.

**Lowell:** (479) 770-4343 **Springdale:** Harps (479) 751-9300 Fax (888) 770-6855