MSUC
MORNING STAR URGENT CARE

Established Patient Visit

Patient Name: _____

Sex: ☐ Male ☐ Female ☐ Other **Date of Birth:** ____ / ____ / _____

Mailing/Physical Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____**Phone Number:** _____

Primary Care Provider: _____ **Last Visit:** ____ / ____ / _____

Pharmacy: ☐ Albertsons ☐ Independence Drug ☐ Smiths ☐ Walmart ☐ CVS ☐ Golden Health Preferred

Lab: ☐ LabCorp ☐ Quest Diagnostics ☐ NNRH **Preferred Imagining Facility:** ☐ HDI ☐ NNRH

Reason for Today's Visit:

_____

Duration of the symptoms: _____

Symptoms (check all that apply): ☐ Fever ☐ Chills ☐ Cough ☐ Shortness of Breath ☐ Chest Pain ☐ Nausea/Vomiting ☐ Diarrhea ☐ Abdominal Pain ☐ Headache ☐ Sore Throat ☐ Rash ☐ Injury ☐ Other

_____

Pain Level (0-10): _____

Allergies

☐ **No New Allergies**

Allergy	Allergic Reaction

Medications

☐ **No New Medications**

Medications (list all)	Dose	Times Per Day