

**Long Point Urgent  
& Family Care**  
ROPER ST. FRANCIS PHYSICIANS

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Gender M/F

**Primary Care Physician:** \_\_\_\_\_

Please initial here \_\_\_\_\_ if you would like us to fax today's notes to your primary care physician.

Who referred you to us? \_\_\_\_\_

Reason for Today's Visit

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How long have you had this problem? \_\_\_\_\_

How have you been treating it? (Doctor, Medications, etc.)

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Is this an injury? Yes / No                      Car / Work / Other

Date of Injury \_\_\_\_/\_\_\_\_/\_\_\_\_

Time of injury \_\_\_\_:\_\_\_\_

State injury occurred \_\_\_\_\_

Place of accident \_\_\_\_\_

How did the accident happen?

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If work accident: Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Do you have any drug allergies? Yes (list below) No

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What medical conditions have you been diagnosed with in the past?

Disease                      Date diagnosed                      Disease                      Date diagnosed

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What surgeries have you had in the past?

Surgery                      Date                      Surgery                      Date

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Current prescription and/or over the counter medication(s)

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**Tobacco Use:** Yes/No

**Alcohol Use:** Yes/No