United
Medical House Calls

TELEMEDICINE URGENT CARE FORM

****PATIENT INFORMATION****

Name:_____

Street:_____

Facility/Complex_____

_____

Town/State/Zip:_____

_____

Contact Information:

Phone:_____

Email:_____

Date of Birth_____/_____/_____

Sex: M F

Cell:_____

****PRIMARY INSURANCE****

Insurance Company:_____

Claim Address:_____

City/state/Zip:_____

Group #:_____

Policy/ ID# :_____

Name on Card:_____

Date of Birth:_____

Soc Security #:_____

Effective Date:_____

Have you or someone you know contracted the COVID-19 virus or "CORONA VIRUS"? ☐Yes ☐No

What is the reason for your call today? (PLEASE BE SPECIFIC)

_____

_____

_____

_____

_____

_____

How long have you had these symptoms?:

_____

Is anyone else in the home sick? If so, who?

_____

Which of the following conditions are you currently being treated for or diagnosed with in the past? (Please check)

☐Heart disease / Murmur / Angina ☐High cholesterol ☐High blood pressure

☐Low blood pressure ☐Anemia or blood problems ☐Swollen

☐Heartburn (reflux) ☐Shortness of breath ☐Asthma

☐Sinus problems ☐Seasonal allergies ☐Tonsillitis

☐Ear problems ☐Lung problems / cough ☐Eye disorder / Glaucoma

☐Seizures ☐Stroke ☐Head aches / Migraines ☐Neuro-

logical problems ☐Depression / Anxiety ☐Psychiatric care

☐Diabetes ☐Kidney / Bladder problems ☐Liver problems / Hepatitis

☐Arthritis ☐Cancer ☐Ulcers/colitis

☐Thyroid problems

Please Describe any current or past medical issues not listed above

_____

_____

_____

Please list your past surgeries/ other concerns

_____

_____

_____

Allergies

Are you Allergic to penicillin or other drugs? ☐Yes ☐No

Please list:_____

Have you ever had to use an Epinephrine Pen? ☐Yes ☐No If Yes, date administered:_____

Medications: (PLEASE LIST ALL MEDICATIONS)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Social and Preventive History

Do you currently smoke or chew tobacco?	☐Yes ☐No	If no, have you in past?	☐Yes ☐No
Do you drink alcohol, beer, or wine?	☐Yes ☐No	If no, have you in past?	☐Yes ☐No
Do you currently drink coffee or tea?	☐Yes ☐No	If yes, how many cups per day?_____	
Do you wear a helmet when riding bike?	☐Yes ☐No	Do you exercise weekly?	☐Yes ☐No
Do you wear seatbelt when driving?	☐Yes ☐No		

Who is your regular PRIMARY CARE provider?

_____

_____

_____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true, and accurate.

Patient/ Legal Guardian Signature_____ Date:_____