

CURRENT MEDICATIONSDrug allergies: No Yes

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

(Please provide medication list if available)

Name of drug	Dose (include strength & number of pills per day)

MEDICAL HISTORY

Do you now or have you ever had any of the following listed below?

- | | | |
|--|--|--|
| <input type="checkbox"/> NONE | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney stones | |
| <input type="checkbox"/> Heart problems | | |

Other Medical Conditions:

ADDITIONAL INFORMATION

Referring Doctor: _____

Address: _____

Phone Number: _____

Primary Care Doctor: _____

Address: _____

Phone Number: _____

In general, overall you would say your health is:

- Excellent Good Fair Poor

Exercise Habits: _____

Are you pregnant? Yes No

Are you nursing? Yes No

Emergency Contact: _____

Phone Number: _____

Relationship: _____

Medicare Patients only:

Have you been seen by OR are you currently being seen by a Home Health Care Agency medical care or services?

- Yes No If

yes, When? _____

Patient Signature: _____

Date: _____