Health Intake Form

DATE: _____

INTERVIEWER: _____

PATIENT NAME: _____

AGE: _____ DATE OF BIRTH: _____

HEIGHT: _____ WEIGHT: _____ BP: _____

PULSE: _____ RESP. RATE: _____

Have you been vaccinated against any of the following?

		Date of vaccine or illness			Date of vaccine or illness
Chicken pox	Y/N		Measles	Y/N	
Mumps	Y/N		Rubella	Y/N	
Hepatitis B	Y/N		Tetanus	Y/N	

Do you have any of the following?

Asthma	Y/N	Allergies	Y/N
Eczema	Y/N	Headaches	Y/N
Stomach Pain	Y/N	Back pain	Y/N
Dizziness	Y/N	Earaches	Y/N

Are you allergic to any medications? Y/N

If yes, please list: _____

_____

Have you ever been hospitalized? Y/N

If yes, please explain: _____

_____

Do you wear glasses? Y/N

Do you wear contact lenses? Y/N