# Health Intake Form

Date _____/_____/_____

Interviewer _____

Name _____

Age _____ Date of Birth _____/_____/_____

Have you had vaccinations for any of the following?

☐ Chicken pox ☐ Measles

☐ Mumps ☐ Rubella

☐ Hepatitis B ☐ Tetanus

Do you have any of the following?

☐ Asthma ☐ Allergies

☐ Eczema ☐ Headaches

☐ Stomach pain ☐ Back pain

☐ Dizziness ☐ Earaches

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list: _____

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do you wear contact lenses? ☐ Yes ☐ No

Do wear glasses? ☐ Yes ☐ No