HEALTH INVENTORY

Name: _____
(Last) (First) (Middle Initial)

Home Address: _____
(#) (Street) (City) (State) (Zip)

Are you currently living in an assisted living facility? ☐ Yes ☐ No

If yes, which one: _____

Home Ph: _____ Cell Ph: _____ SS#: _____

Date of birth: _____ Place of birth: _____ Age: _____

Email: _____

How did you hear about us? _____

Preferred pharmacy for electronic prescriptions (Please include address or phone number if possible):

_____

Place of employment: _____ Phone #: _____

What did you do for work before you retired? _____

Marital status: _____ # of children: _____

Emergency contact: _____Phone #: _____

Please list any physicians that you would like us to send our notes:

Name: _____

Name: _____

Name: _____

Name: _____

Name: _____

Your Initials: _____

Please list any surgery (past surgical history) you have had and the approximate dates:

_____

_____

_____

_____

Please list all medical conditions (past medical history) and the approximate dates:

_____

_____

_____

_____

_____

Please list all medications and dosages you are currently taking: _____

_____

_____

_____

_____

Please list all medications to which you are allergic: _____

Did you receive your influenza vaccine this flu season? If not, are you planning on it? ☐ Yes ☐ No _____

Are you allergic to iodine or contrast? Please circle all that apply.

Do you have any pacemakers, stents, shunts, or anything metallic in your body? If yes, what: _____

Have you ever received Radiation? ☐ Yes ☐ No

If yes, where? _____ When? _____

Do you smoke? ☐ Yes ☐ No How many packs and for how many years? _____

Did you ever smoke? ☐ Yes ☐ No How many packs and for how many years? _____

If yes, when did you stop smoking? _____

Your Initials: _____

Do you drink alcohol? ☐ Yes ☐ No How much? _____

Did you ever drink alcohol? ☐ Yes ☐ No How much? _____

If yes, when did you stop drinking alcohol? _____

If your parents are deceased, what was their cause of death?

Mother: _____Age: _____

Father: _____Age: _____

FAMILY HISTORY

Do you live alone? ☐ Yes ☐ No

Is there any family history of cancer? ☐ Yes ☐ No

RELATIONSHIP	TYPE

RELATIONSHIP	TYPE

FOR WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No Date of last menstrual period: _____

# of Pregnancies: _____ # of Children: _____