UPDATE

☐ Hospice Patient   Today's Date: ___________________________

Patient Name: _________________________________Date of Birth: ________ Sex: ________ Weight: ______ Height: ______

Mailing Address: ______________________________________ City: __________________ State: ________ Zip: ___________

Home Phone: ________________________ Work Phone: _______________________ Cell Phone: _______________________

Emergency Phone (other than your own): _____________________ Name: ______________________ Relationship: ________

Email Address: ____ Primary Care Physician: ___________________________

Please list your current medications, including OTC medications/vitamins/herbs. Please include prescription, over-the-counter, herbs, vitamins/supplements):

Name	Dosage	Directions	Route of Administration

Are you allergic to any medications? ☐ Yes ☐ No If yes, please list: ____

Do you have now or have you ever had the following diseases or conditions:

Lungs:	Yes	No
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Tuberculosis	☐	☐
Vascular:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Mitral Valve Prolapse	☐	☐

Other Systemic:	Yes	No
Diabetes	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Gastrointestinal	☐	☐
Hepatitis or Jaundice	☐	☐
Glaucoma	☐	☐
Arthritis/Joint	☐	☐
Epilepsy or Seizures	☐	☐
Fainting	☐	☐
Bleeding Tendency	☐	☐
Difficulty Healing	☐	☐
Emotional Disorders	☐	☐
HIV+	☐	☐

Artificial/Implanted Devices:	Yes	No
Hip	☐	☐
Knee	☐	☐
Shoulder	☐	☐
Pins or Screws	☐	☐
Heart Valve(s)	☐	☐
Heart Stent(s)	☐	☐
Defibrillator	☐	☐
Pacemaker with Defibrillator	☐	☐
Pacemaker w/o Defibrillator	☐	☐
Implanted Brain Devices	☐	☐
Other: __________________	☐	☐
Other: __________________	☐	☐

Are you currently pregnant, planning a pregnancy, or breastfeeding? ☐ Yes ☐ No
Do you have a history of cancer? ☐ Yes ☐ No If yes, please list: _______________
Do you have a family history of malignant melanoma? ☐ Yes ☐ No If yes, whom?: ________________
Have you had a flu shot this season? (October thru March) ☐ Yes ☐ No
For patients 65 and over, have you received the pneumococcal vaccine? ☐ Yes ☐ No
Are you under the care of Hospice? ☐ Yes ☐ No
Do you bleed easily? ☐ Yes ☐ No
Do you use tobacco products? ☐ Yes ☐ No Type/frequency _________ Are you interested in cessation counseling? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No If yes, amount per week: _____

Have you had any changes in your health insurance? ☐ Yes ☐ No **If yes, please present cards to our receptionist so she may make a copy and update your account.*

(Updated July 2017)