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)