Hybrid Health PAC

Personal Health Information:

Name:_____ Phone:_____ OK to text: Y / N

Email:_____ Alternative phone: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____ Phone: _____

Health History

DOB:___/___/___ SEX: M / F

Primary Care Provider: _____

Do you have ANY allergies to medications, foods, latex, or other substances?_____

_____

Are you currently being treated for any medical conditions?_____

_____

Are you currently taking any prescribed medications, over the counter medications, vitamins or supplements?_____

_____

Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?_____

_____

Do you currently have any of the following:

Heart (surgery, disease, attack	Y / N	Type I Diabetes	Y / N	Psychiatric Disorders	Y / N
Chest pain	Y / N	Type II Diabetes	Y / N	Depression	Y / N
Congenital Heart Disease	Y / N	Ulcers	Y / N	Nervous/Anxious	Y / N
Heart murmur	Y / N	Thyroid Problems	Y / N	Cancer	Y / N
High Blood Pressure	Y / N	COPD	Y / N	Chemotherapy	Y / N
Mitral Valve Prolapse	Y / N	Emphysema	Y / N	Hepatitis A B C	Y / N
Artificial Heart Valve/ Pacemaker	Y / N	Tuberculosis	Y / N	AIDS/HIV	Y / N
Swollen Ankles	Y / N	Asthma	Y / N	Blood Transfusion	Y / N
Stroke	Y / N	Allergies	Y / N	Bruise Easily	Y / N
Rheumatic Fever	Y / N	Sinusitis	Y / N	Sickle Cell Disease	Y / N
Arthritis/Rheumatism	Y / N	Neurological Disorders	Y / N	Hemophilia	Y / N
Artificial Joint	Y / N	Epilepsy/Seizures	Y / N	Liver disease	Y / N
Kidney Problems	Y / N	Dizziness/Fainting	Y / N	Jaundice	Y / N

Are you currently **pregnant** or **breastfeeding**? Y/N

Any other health related issues you would like us to be aware of:_____

_____

_____ _____

Patient signature Date