MEDICAL INTAKE

Residents Full Legal Name: _____

Address:_____City_____ State____ Zip

Code_____

Date of Birth:_____ Age_____

Primary Physicians Name, Phone, and

Address:_____

_____

Health Insurance Provider (if applicable):_____

Known

Allergies:_____ _____

Known Illnesses or Diseases such as Cancer, Hepatitis, Diabetes, Aides,

Asthma, Herpes, ETC. If so, please

explain:_____

_____

Do you smoke? YES NO

If so, how often_____

Do you drink alcohol? YES NO

If so, how often_____

Do you have any concerns currently that are needing medical attention? YES

NO

If so, please

explain:_____

Last medical exam_____

Have you ever had surgery? YES NO

Are you currently taking any prescribed medications? YES NO

If so, please

list: _____

_____

Have you ever abused prescription

drugs?_____

Dentists Name, Phone, and

Address_____

_____

Last appointment _____

Resident Signature: _____

Date: _____

Freedom House Representative_____

Date: _____