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: _____

FREEDOM HOUSE : P.O. BOX 850

SLOCOMB, AL 36375