

Client Information

Name _____ Date of Birth _____ Phone _____
 Address _____ City/State/Zip _____
 SSN _____ Medicare _____ Other Insurance _____
 Marital Status _____

NOTIFY IN CASE OF EMERGENCY:

Name _____ Relation _____
 Phone _____

Primary Physician _____ Phone _____

Address _____

Hospital Preference _____

Allergies To Meds: _____

Immunizations:	
Pneumonia _____	TB _____
Tetanus _____	Flu _____
Hepatitis _____	Other _____

Implantable Devices: Defib/Pacemaker	
_____ Y _____ N	Explain _____
Respiratory:	
Chronic Cough _____	Wheezing _____ Sputum _____
Shortness of Breath _____	Oxygen Use _____

Patient History (check all that apply):			
_____ Heart Disease	_____ Cancer	_____ Breathing Problems	_____ Anemia
_____ Hypertension	_____ Last rad. date _____	_____ Mental/Emotional	_____ Kidney/Bladder
_____ Blood Clots	_____ Last chemo date _____	_____ Hyper/Hypothyroid	_____ Arthritis
_____ Diabetes	_____ Stroke	_____ Stomach/Bowel	_____ Movement Restrictions
_____ Back	_____ Bleeding	_____ Fractures	_____ Seizures
_____ Skin Condition	_____ Rashes	_____ Decubitus Ulcers	_____ Other _____

Medications:			
Medication	Dose	Medication	Dose

Nurses Notes: _____

RN Signature: _____ Date: _____