



Health for Friends
 "Healthcare that cares."

Date _____

First Name _____ MI _____ Last Name _____

Address _____ City NORMAN Zip _____ County CLEVELAND

Employment Status: Employed Unemployed Phone # _____ 2nd # _____

Ethnicity: (please circle one)

African American Asian Caucasian Hispanic Native American Other _____

Sex: Male Female Marital Status: Single Married Divorced Separated Widow

Date of Birth _____ Age _____ SS# _____ - _____ - _____

of children in household _____ # of individuals residing in household _____

Are you a veteran? Yes No Are you a U.S. Citizen? Yes No

Insurance Status: (please circle one) Insured Uninsured

Education Level: (please circle one) Less than HS High School Graduate GED Recipient
 Some College College Student College Graduate

Primary Language: English Spanish Other: _____

Current Monthly Income: Income includes salary / wages, child support, social security, retirement benefits, SSI, Disability, pension, unemployment, food stamps, rental income, workman's comp, veteran benefits, investment income and any other revenue.

Source _____ \$ _____ Source _____ \$ _____

Source _____ \$ _____ Source _____ \$ _____

Total Monthly Income: Patient \$ _____ Household \$ _____

HIPAA Authorization

I authorize Health for Friends to leave messages on my home phone. YES NO

I authorize Health for Friends to leave messages on my cell phone. YES NO

I authorize the following individual(s) to receive information regarding my health care at Health for Friends.

Allergies: Reactions to Medicines / Foods / Other Agents:

Allergen	Reaction or Side Effect

Medical History: Please check any box that applies in your history

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anticoagulation | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eye Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma / COPD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Major Blood Vessel | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> GERD | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood / Plasma | <input type="checkbox"/> Gout | <input type="checkbox"/> Nerve Disease | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Cancer (type) _____ | | |
| <input type="checkbox"/> Other _____ | | | |

Infectious Diseases: Please check any box that applies in your history

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cholera | <input type="checkbox"/> Filariasis / Elephantitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Guinea Worm | <input type="checkbox"/> Parasite Infection | <input type="checkbox"/> Trachoma |
| <input type="checkbox"/> Dengue | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Poliomyelitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Ebola | <input type="checkbox"/> Malaria | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Veneral Diseases _____ | | <input type="checkbox"/> Other _____ | |

Medications: List all prescriptions, non-prescription medicines, vitamins, herbs and home remedies you currently take.

Medication	X's per day	Dose	Prescribed By

Family History: Check if member of your family had any of the following and their relation to you.

- | | | | |
|--|----------|---|----------|
| Condition | Relation | Condition | Relation |
| <input type="checkbox"/> Heart Disease | _____ | <input type="checkbox"/> Cancer | _____ |
| <input type="checkbox"/> High Blood Pressure | _____ | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Asthma | _____ | <input type="checkbox"/> Mental Illness | _____ |
| <input type="checkbox"/> Alcoholism | _____ | <input type="checkbox"/> | _____ |