For Office Use Only:

Acct #: _HF_____ Date of Service: _____ Room #: _____

New PT _____ Established PT _____

Name: _____ **DOB:** _____ **Age:** _____

Male: ____ **Female:** ____ **If female, date of last menstrual period**: _____

Primary Care Physician: _____ **Preferred Pharmacy:** _____

Allergies (drug, latex, food, etc.): _____

Tobacco User: Never_____ Former_____ Current_____ **Packs/Day:** _____

Type: Cigarettes_____ Cigar_____ Pipe_____ Dip _____ Chew_____ Vape/eCig_____

Alcohol User: Yes No **Type:** Beer_____ Wine_____ Liquor_____ **Drinks/Week:** _____

Family History:

Please list family member (Mother/Father, Paternal/Maternal Grandparent) and check all that apply:

Family Member	Still Living	Diabetes	High Blood Pressure	Heart Disease	Cancer
	Yes No				
	Yes No				
	Yes No				

Reason for Todays Visit:

- ☐ Chills
- ☐ Sinus Congestion
- ☐ Sinus Pain
- ☐ Nasal Congestion
- ☐ Upper Respiratory Symptoms
- ☐ Chest Congestion
- ☐ Cough
- ☐ Wheezing
- ☐ Sore Throat
- ☐ Diarrhea
- ☐ Fever
- ☐ Nausea
- ☐ Vomiting
- ☐ Flu Like Symptoms
- ☐ Abdominal Pain
- ☐ Urinary Tract Symptoms
- ☐ Back Pain
- ☐ Eye Irritation - R/L
- ☐ Headache/Migraine
- ☐ Ear Pain - R/L
- ☐ Rash
- ☐ Sprain/Strain
- ☐ Laceration
- ☐ Injury DATE: _____
- ☐ Other: _____

_____

_____

Duration: Day(s)_____ Weeks_____ Months_____

Treatments Tried: _____ **Did it help?** _____

For Office Use Only:

Injection	Lot #	Expiration	DR	Nurse	Dr.'s Orders/Amount
Decadron					
Rocephin					
Toradol					
Zofran					
Phenergan					
TDAP/TD					
B12					
Celestone					
Kenalog					
DepoMedrol					

HT: _____ WT: _____ B/P: _____/_____

Temp: _____ $SP0^2$: _____% HR: _____