

ADVANCED Health Resources

Patient Questionnaire

Personal Data

Please print clearly

Country born in: _____ Date: _____

Last Name: _____ First Name: _____ Middle Name: _____

Date of Birth: _____ Age: _____ Sex: Male _____ Female: _____

SSN # _____ Marital Status: _____

Home Address: Street _____

City, State, Zip: _____

Employer: _____

Occupation: _____

Work Address: Street _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Referred By: _____

Primary Care Physician: _____

Address: _____

ADVANCED Health Resources

I-693 MEDICAL QUESTIONNAIRE

Name: _____ Age: _____ Date: _____
(Please Print)

Do you have any chronic illnesses? If yes, please explain. _____	YES	NO

Have you ever been hospitalized? If yes, please explain _____	YES	NO

Have you ever had any surgeries? If yes, please explain _____	YES	NO

Have you ever had chickenpox (Varicella)? <i>**This is a normal disease that many young children have had.</i>	YES	NO
Have you ever had a Tuberculosis skin test? If yes, did the test site become reddened or swollen? Did you have a chest x-ray after the skin test? Have you taken medication for tuberculosis?	YES YES YES YES	NO NO NO NO
Have you ever tested positive for HIV? If yes, when did you test positive? _____	YES	NO
Have you ever had a sexually transmitted disease? If yes, please explain _____	YES	NO

Do you have a history of mental illness or depression?	YES	NO
Have you ever used drugs (narcotics) not prescribed by your physician? If yes, what, how much and how frequently? _____ Have you ever joined or been told to join a support group for narcotics use/abuse?	YES YES	NO NO
Do you drink alcohol? If yes, what, how much and how frequently? _____ Have you ever joined or been told to join a support group for alcohol use/abuse?	YES YES	NO NO
Have you ever been arrested or in jail? If yes, please explain _____	YES	NO

This information is required for the purpose of assisting the practitioner to determine your medical status. Failure to provide full information concerning your health could result in the hampering of the medical review process. The information on this form is used solely for medical and administrative purposes. No one other than the reviewing practitioner and staff will have access to this medical form and information without your written authorization.

Signature _____ Date: _____

Health Questionnaire

Weight: _____ Age: _____

Please circle yes or no

Are you allergic to any drug, medication, vaccine or vaccine component? YES NO

Are you allergic to eggs, yeast or any other foods? YES NO

Are you currently taking any medications? YES NO
If yes, please list. _____

Have you ever had a serious reaction after receiving a vaccination? YES NO

Are you sick or do you have a fever today? YES NO

Do you, any person who lives with you, or any person you take care of take: cortisone, prednisone, any other steroids, chemotherapy (anticancer drugs), or radiation therapy (x-ray treatments)? YES NO

Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problem? YES NO

During the past year have you received a transfusion of blood or plasma, or been given a medicine called immune globulin? YES NO

FOR WOMEN:

Are you pregnant? YES NO

Do you plan to become pregnant within the next three months? YES NO

Are you breastfeeding (nursing) now? YES NO

Did you bring your immunization record with you? YES NO

It is important for you to have a personal record of your vaccines. If you do not have a record, ask for one and always bring this record with you for clinic visits. Make sure that all of your immunizations are recorded.

Consent for Vaccination: It has been explained to me, in a way that I understand, both the risks and benefits of the vaccine(s) that I am to be given. I have been given vaccine information sheets and have had the opportunity to ask questions. I consent to the administration of the following vaccine(s):

- Polio IPV MMR Tet/diphth Varivax Hep A Hep B Influenza
 Pneumonia Meningitis HPV (Human Papilloma Virus) Varicella Zoster PPD Test

Date:

Patient Signature or parent or guardian or authorized person

Date	Vaccine	Manufacturer	Lot #	Dose/Route	Injection Site	Exp. Date

