



<b>Health Information:</b>										
Do you have an Advance Directive?					Location:					
What hospital do you prefer to use?					Blood Type:					
What is your current insurance?					Insurance Number:					
I have never smoked		Yes	I currently smoke			packs per day	I have smoked for			years
Do you use other forms of tobacco?		Yes	No		Yes	No	Do you drink alcohol?		Yes	No
How often/how much?					How often/how much?					
I formerly smoked but stopped in: (list year)										
<b>Medical / Surgical History:</b> Please list any Illness/Operations/Injuries and the dates on which they occurred.										
Do you wear contact lens or glasses?		Yes	No		Do you have a swallowing difficulties?			Yes	No	
Do you have an artificial eye?		Yes	No		Right	Left				
Are you legally blind?		Yes	No		Right	Left	Both			
Do you wear dentures?		Yes	No		Upper	Lower	Both	Partial plate		
Do you have a hearing impairment?		Yes	No		Right	Left	Both			
<b>Device Information:</b>			<b>Equipment Information:</b>			<b>Prosthetic/Orthotics Information:</b>				
Type:			Type:			Type:				
Contact Physician:			Vendor/Provider:			Provider:				
Frequency of checks/refills:			Contact # of vendor/provider:			Components:				
Date of last check or refill:			Date of last service:			History:				
Model # if applicable:						Date of last service:				
<b>Have you ever been treated for:</b>										
Anemia	Yes	No	Epilepsy	Yes	No	Liver Disease	Yes	No		
Arthritis	Yes	No	Glaucoma	Yes	No	Leukemia	Yes	No		
Asthma	Yes	No	Heart disease	Yes	No	Lung disease	Yes	No		
Alcohol problems	Yes	No	Heart Murmur	Yes	No	Lupus	Yes	No		
Bleeding Tendency	Yes	No	Hepatitis	Yes	No	Rheumatic Fever	Yes	No		
Cancer	Yes	No	High blood pressure	Yes	No	Stroke/TIA	Yes	No		
Congenital Heart problem	Yes	No	High cholesterol	Yes	No	Tuberculosis (TB)	Yes	No		
Depression	Yes	No	Jaundice	Yes	No	Thyroid disease	Yes	No		
Diabetes	Yes	No	Kidney disease	Yes	No	Ulcers	Yes	No		
Other health problems:										
<b>Spiritual Information:</b>										
Would you like your Minister / Priest / Rabbi / Other to be notified? (Circle One)										
Name:										
Telephone:										
<b>Signs and symptoms for which I should seek emergent care:</b>										
<b>Risk factors not previously addressed on this form:</b>										
<b>Comments:</b>										