|  |  |  |
| --- | --- | --- |
| Client Name:  | DOB: | Age: |
| Weight: | Height: | BP: | HR: |

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| **MEDICATIONS** |
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| **Are there any abnormalities in the following systems?** | Comments |
| --- | --- |
| Head |  Yes No |  |
| EENT |  Yes No |  |
| Respiratory |  Yes No |  |
| Cardiovascular |  Yes No |  |
| Gastrointestinal |  Yes No |  |
| Genitourinary |  Yes No |  |
| Metabolic/Endocrine |  Yes No |  |
| Nervous System |  Yes No |  |
| Skin |  Yes No |  |
| Hematology |  Yes No |  |
| Musculoskeletal |  Yes No |  |

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| --- | --- |
| **MEDICAL HISTORY** | Comments |
| Injuries (in past year) |  Yes No |  |
| Asthma |  Yes No |  |
| Allergies (Seasonal) |  Yes No |  |
| Allergies (to medicine) |  Yes No |  |
| Allergies (food) |  Yes No |  |
| Seizures |  Yes No |  |
| Mental Illness |  Yes No |  |
| Hospitalizations (in past year) |  Yes No |  |
| Swallowing Precautions |  Yes No |  |

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| Physician’s Signature: Date:  |
| Phone: Fax:  |
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