|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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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