South San Francisco Adult Education

**Student Name:** Click here to enter text.

**Patient Medical Form**

|  |  |
| --- | --- |
| First Name ick here to enter text. Last Name Click here to enter text. | |
| Address Click here to enter text. | |
| City Click here to enter text. State Click Zip Code enter text. | |
| Home Phone: to enter text. | Work Phone: Click here to enter text. |
| Email address: Click here to enter text. | |
| Birthday: Click here to enter a date. Age: t. Sex: M F | |
| Did you have in the past any of the following:    Yes No  diabetes  measles  mumps  rubella  high blood pressure  chicken pox  allergies  polio  TB | |
| YES NO  Have you ever had heart problems?  Have you ever had kidney problems?  Have you ever had lung problems?  Have you ever had liver problems?  Have you ever had bladder problems?  Have you ever had stomach problems?  Have you ever had an operation?  If yes, when? Click here to enter text.  What was the date of your last medical check-up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| What **prescription medicines** are you taking now?  1 Click here to enter text. How long? Click here to enter a date.  2. Click here to enter text. How long? Click here to enter a date.  3 Click here to enter text. How long? Click here to enter a date. | |
| Do you have medical insurance? Yes  No | |
| Name of your insurance :Click here to enter text. | |
| Signature Click here to enter text.  Date Click here to enter a date. | |