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 Nodiabetes [ ]  [ ] measles [ ]  [ ] mumps [ ]  [ ] rubella [ ]  [ ] high blood pressure [ ]  [ ] chicken pox [ ]  [x] allergies [ ]  [ ] polio [x]  [ ]  TB [ ]  [x]  |
|  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. |