Hospital for *Special* Care
Outpatient Health History

Office Label

Name: ____
First Middle Last

Date of Birth: ____________ Age: ________ Sex: ❑ Male ❑ Female ❑ Decline to Answer

Email address: ____________________________

Alternate contact Name: __________________________ Phone: ___________________________

Primary Language Spoken: _____________________ Interpreter needed? ❑ Yes ❑ No

Do you have any trouble with your hearing? ❑ Yes ❑ No Interpreter needed? ❑ Yes ❑ No

Describe: ____

Do you have any trouble with your vision? ❑ Yes ❑ No Describe: _________________________

Best way I learn: ❑ Explanation ❑ Handout ❑ Demonstration ❑ Audio/visual

Primary Doctor for medical care (General Practitioner/Internist):

Name: ____________________________________ Phone#:__________________

Address: ____

Pharmacy name: ____________ Street, Town _________________________________ zip code___________

List any Hospitalization/Surgeries/Significant Procedures/tests below (i.e. X-Ray, CT scan, MRI, other)

Event	Approx. date	Where	By Whom

Have you tried to harm yourself within the last 6 -12 months? ❑ YES ❑ NO

Do you feel like harming yourself now? ❑ YES ❑ NO

Other Medical Conditions (check any that apply):

	Arthritis		Dizziness/Fainting		Joint Replacement		Pregnancy
	Asthma		Emphysema		Kidney Disease		Seizure Disorder
	Cancer		Fractures		Learning Disability		Shortness of Breath
	Chest pain/angina		Head Injury		Liver Disease		Spinal Cord Injury
	COPD		Headache		Migraine		Stomach Disorders
	Depression		Heart problems		Numbness/Tingling		Stroke
	Development Disability		High blood pressure		Osteoporosis		Tuberculosis
	Diabetes		Hypoglycemia		Pace Maker		Ulcers

Do you have pain? ❑ YES ❑ NO Other/Explain: ____

Smoking History:

Current: ❑ YES ❑ NO Past history: ❑ YES ❑ NO Vape: ❑ YES ❑ NO Medical Marijuana: ❑ YES ❑ NO

Are you a US Veteran: ❑ YES ❑ NO

Do you have a Living Will or any Advanced Directives? ❑ Yes ❑ No ❑ Unsure

In order to comply with your wishes we REQUIRE A COPY of any **Living Will or Advanced Directives** to be provided and reviewed with the Outpatient Nurse and placed on file in your Medical Record.

Date ___________ Nursing Staff Name ____________________________ ❑ COPY PROVIDED

You may request an informational packet on Advanced Directives from the Outpatient Receptionist.

Please complete the medication/Allergy list provided.

Patient Signature ____ Date __________________