

PATIENT DATA BASE

SECTION I

Please complete this form concerning your health. The information you provide will be used as a basis for planning your care.

1. What problem(s) brought you to the hospital? _____

2. What do you know about your problem(s)? _____

3. What are you most concerned about right now? _____

4. What significant health problems have you had? _____

5. Have you ever been hospitalized before? No Yes Date _____

6. For what problems have you been hospitalized? _____

7. List drugs/medical you are taking:

Drug	Date/Time Last Taken	Drug	Date/Time Last Taken

8. Do you have allergies to any of the following? If so, please list.

medicines:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
foods:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
adhesive tape:	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____
other	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	_____

9. List the kinds of allergic reactions you have to the items above. _____

10. Do you have any special dietary requirements/restrictions?
No Yes (please explain) _____

ADDRESSOGRAPH