PANCARE OF FLORIDA, INC.

# HEALTH INFORMATION UPDATE

## Patient Information

| Last Name | First Name | Middle Initial |
|---|---|---|
| | | |

| Social Security Number | Date of Birth | Today's Date |
|---|---|---|
| | | |

| Address | City | State | Zip Code | County |
|---|---|---|---|---|
| | | | | |

| Home Phone | Work Phone | Cell Phone |
|---|---|---|
| (  ) | (  ) | (  ) |

| Emergency Contact | Phone | Relationship to Patient |
|---|---|---|
| | (  ) | |

## Health Information

**Date of Last Visit:**_____ **Reason for Today's Visit:**_____

Have you ever had any of the following? Check ☑ those that apply.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | ADHD | ☐ | Coughing Up Blood | ☐ | Head Injury | ☐ | Prostate Problems |
| ☐ | Alcohol Use | ☐ | COVID-19 | ☐ | Heart Attack | ☐ | Radiation |
| ☐ | Anemia | ☐ | Dark or Black Stools | ☐ | Heart Catheterization | ☐ | Rectal Bleeding |
| ☐ | Anxiety | ☐ | Depression | ☐ | Heart Disease | ☐ | Rheumatoid Arthritis |
| ☐ | Artificial Joints | ☐ | Diabetes | ☐ | Heart Murmur/Irregular Beat | ☐ | Seizures |
| ☐ | Asthma | ☐ | Diarrhea | ☐ | Hepatitis A, B, or C | ☐ | Sexual Difficulties |
| ☐ | Autism | ☐ | Dizziness | ☐ | High Blood Pressure | ☐ | Shortness of Breath |
| ☐ | Blood in Stools/Urine | ☐ | Drug Addictions | ☐ | HIV/AIDS (Risk or Exposure) | ☐ | Sickle Cell Anemia |
| ☐ | Blood Disease | ☐ | Earache | ☐ | Jaundice | ☐ | Sleep Difficulties |
| ☐ | Blood Transfusion | ☐ | Emphysema | ☐ | Kidney Disease/Stones | ☐ | Street Drug Use |
| ☐ | Bowel Changes | ☐ | Epilepsy | ☐ | Liver Disease | ☐ | STDs |
| ☐ | Cancer | ☐ | Excessive Bleeding | ☐ | Marital Problems | ☐ | Stroke |
| ☐ | Changing Moles | ☐ | Fainting | ☐ | Mental Health Disorder | ☐ | Suicide Attempt |
| ☐ | Chest Pain | ☐ | Fractures | ☐ | Osteoarthritis | ☐ | Thyroid Disease/Problems |
| ☐ | Cholesterol (high) | ☐ | Gallbladder Disease | ☐ | Pacemaker | ☐ | Tobacco Use/Smoker |
| ☐ | Chronic Cough | ☐ | Gout | ☐ | Pneumonia | ☐ | Tuberculosis (TB) |
| ☐ | Constipation | ☐ | Hay Fever | ☐ | Pregnant-Due Date: | ☐ | Wheezing |

Are you currently having pain or any problems? ☐ Yes ☐ No

If yes, please explain:_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain:_____

Are you now under the care of a physician? ☐ Yes ☐ No

Name of Physician:_____

Do you have any health problems that need further clarification? ☐ Yes ☐ No

If yes, please explain:_____

Are you currently taking any medications, pills, or drugs? ☐ Yes ☐ No

If yes, list medications:_____

Are you allergic to or have you experienced any ill effect from a local anesthetic or any drugs? ☐ Yes ☐ No

If yes, describe (i.e., rash, itching, difficulty breathing, etc.):_____

COVID-19 Vaccination Dose Number: ☐ None ☐ First Dose ☐ Second Dose ☐ Booster Dose x _____

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have a change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent, or guardian:_____ Date:_____

Provider's Signature:_____ Date:_____