

Patient Health Information – Orchard School Clinic

| Name | : | | | Date of Birth:/ / | | | |
|-------|-------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|-------|------------------|---------------------------------------------------------------------------------------------------------------------------|
| Do yo | u hav | e ANY ALLEF | RGIES or SENSITIVITIES: | Yes 🗖 N | ο Ifγ | ves, please list | t below: |
| | | | | | 1 | | |
| | | ns: List med | | | | | you take with or without a prescription: |
| | | lease 🗹 whei nily Who | re you or members of your far | mily (parents Patient | | | s) have had the following diseases or problems: |
| | | | Anxiety Asthma | | _ | | |
| | | | Bleeding Disorder or Blood Clots Cancer or Tumor Diabetes Domestic Violence Drug Abuse | | | | Mental Illness Stroke Suicide Attempt Thyroid Disease Tobacco Use |
| | | | Eczema Emphysema Epilepsy/Seizures Eye Problems Glaucoma HIV/AIDS Heart Disease | | | | s: |

Patient/Guardian Signature

Date