Patient Health Information – Orchard School Clinic

Name: _____ Date of Birth: ___/___/____

Do you have **ANY ALLERGIES** or **SENSITIVITIES**: ❑ Yes ❑ No If yes, please list below:

_____ _____ _____

_____ _____ _____

Medications: List medicines, birth control pills, herbal supplements or vitamins you take with or without a prescription:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Illnesses: Please ☑ where you or members of your family (parents, grandparents, siblings) have had the following diseases or problems:

Patient	Family	Who		Patient	Family	Who	
❑	❑	_____	ADHD	❑	❑	_____	High Blood Pressure/Hypertension
❑	❑	_____	Alcoholism	❑	❑	_____	Kidney/Bladder Problems
❑	❑	_____	Anxiety	❑	❑	_____	Liver Disease, Hepatitis, Yellow Jaundice
❑	❑	_____	Asthma	❑	❑	_____	Mumps, Measles, Chicken Pox
❑	❑	_____	Bleeding Disorder or Blood Clots	❑	❑	_____	Mental Illness
❑	❑	_____	Cancer or Tumor	❑	❑	_____	Stroke
❑	❑	_____	Diabetes	❑	❑	_____	Suicide Attempt
❑	❑	_____	Domestic Violence	❑	❑	_____	Thyroid Disease
❑	❑	_____	Drug Abuse	❑	❑	_____	Tobacco Use
❑	❑	_____	Eczema				
❑	❑	_____	Emphysema			Other Illnesses:	
❑	❑	_____	Epilepsy/Seizures	❑	❑	_____	_____
❑	❑	_____	Eye Problems	❑	❑	_____	_____
❑	❑	_____	Glaucoma	❑	❑	_____	_____
❑	❑	_____	HIV/AIDS	❑	❑	_____	_____
❑	❑	_____	Heart Disease	❑	❑	_____	_____

_____ _____

Patient/Guardian Signature Date