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
- ☐Allergies:_____ _____
- ☐Anemia
- ☐Anxiety
- ☐Arthritis
- ☐Artificial Joints
- ☐Asthma
- ☐Autism
- ☐Blood Disease
- ☐Blood Transfusion
- ☐Cancer
- ☐Cholesterol (high)
- ☐Codeine Allergy
- ☐Depression
- ☐Diabetes
- ☐Dizziness
- ☐Drug/Alcohol Addiction
- ☐Emphysema
- ☐Epilepsy
- ☐Excessive Bleeding
- ☐Fainting
- ☐Glaucoma
- ☐Growths
- ☐Hay Fever
- ☐Headaches
- ☐Head Injuries
- ☐Heart Disease
- ☐Heart Murmur
- ☐Hepatitis A, B or C
- ☐High Blood Pressure
- ☐HIV/AIDS
- ☐Jaundice
- ☐Kidney Disease
- ☐Liver Disease
- ☐Mental Disorders
- ☐Nervous Disorders
- ☐Pacemaker
- ☐Penicillin Allergy
- ☐*Currently* Pregnant:
  *Due Date:*_____
- ☐Radiation Treatment
- ☐Respiratory Problems
- ☐Rheumatism
- ☐Shortness of Breath
- ☐Sickle Cell Anemia
- ☐Sinus Problems
- ☐Smoker / Tobacco User
- ☐Stomach Problems
- ☐Stroke
- ☐Thyroid Problems
- ☐Tuberculosis
- ☐Tumors
- ☐Ulcers
- ☐Venereal Disease
- ☐Other:_____ _____

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

If yes, please explain:_____

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 ever experienced any ill effect from a local anesthetic or any drugs? ☐ Yes ☐ No

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

To the best of my knowledge, all of 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:_____