



Health Center Flow Sheet

Please complete while you are waiting to be seen-Thank you!

DATE: _____ TIME: _____ PHONE NUMBER: _____
EMAIL: _____

LAST NAME: _____ FIRST NAME: _____

ARE YOU A PILOT? Yes No FLORIDA TECH ATHLETE? Yes No

Reason for visit today?

SMOKER:	YES	NO	# OF PACKS PER DAY _____		
Health Promotion:			If you smoke , would you like information on how to quit?	YES	NO
			Do you drink alcohol? How many drinks in a typical week? _____	YES	NO
			Would you like information on birth control/sexually transmitted diseases?	YES	NO
			If you are a female, are you up to date with gynecological exams?	YES	NO
			Is there any possibility or concern that you are pregnant?	YES	NO
			If you are a male, have you been given information on testicular cancer?	YES	NO
			Do you exercise?	YES	NO

Please check any of the following problems or concerns you have had recently: (All of your responses are completely confidential and will not be shared with anyone without your permission. Your honesty will help us to help you in promoting your general health and well being.)

- | | | |
|--|---------------------------------|--|
| _____ Fever | _____ Constipation | _____ Thoughts of hurting yourself |
| _____ Sore throat | _____ Skin Rash | _____ Lack of Interest in Life |
| _____ Ear Pain | _____ Nausea | _____ Energy |
| _____ High Blood Pressure | _____ Vomiting | _____ Concentration |
| _____ Crying/ Mood swing | _____ Heart palpitations | _____ Anger |
| _____ Irregular menstrual cycle | _____ Weight loss/gain | _____ Relationships with friends/family/significant others |
| _____ Back pain | _____ Appetite | _____ Sadness |
| _____ STD'S | _____ Guilty Feeling | _____ Financial Problems |
| _____ Headaches | _____ Weak/Tired | _____ Grades or missing class |
| _____ Additional Concerns: SPECIFY _____ | | |

The Health Center believes that Health is more than just treating illnesses. Many times problems arise that can affect our ability to do and feel our best. Are there any issues that concern you at school that you have not been able to remedy? Do you have any friends whose behaviors are of concern to you? Can we help or perhaps assist you in finding someone that can?

To ensure there is no misunderstanding of the billing practices of the student health center, please read and sign the following:

I understand that office visits are free to registered students at Florida Tech. However, any procedures, supplies, laboratory work, diagnostic tests, or annual/routine exams will be billed to my insurance or billed directly to me. If I have any questions or don't understand, I will discuss with provider. I will provide any insurance changes on date of services.

Signature: _____

Date: ____/____/____



OFFICE USE ONLY

DATE: _____ PHONE NUMBER: _____ DOB: _____ AGE: _____

LAST NAME: _____ FIRST NAME: _____

Patient Complaint: _____

ALLERGIES TO ANY MEDICATION(S):

CURRENT MEDICATION(S):

WT: _____ **BP:** _____ / _____ **TEMP:** _____ **PULSE:** _____

PEAK FLOW _____ / _____ / _____ **VISION: R- 20/** _____ **L- 20/** _____

O) Appearance NAD other: _____ M/S: A&Ox3 PERLA _____ EOMI _____ Meningeal signs _____
Mood: _____ Affect: Appropriate Other: _____
Tympanic Membranes: Intact Perforated + Light Reflex Red/Dull Air/Fluid Level _____
Sinus: Pain with Percussion Yes No Nasal Mucous Membranes Pale Boggy Erythema Clear _____
Posterior Pharynx/tonsils: Edema Erythema Exudate Normal _____
Other: _____
Neck: thyroidmegaly _____ Lymph Nodes: No Cervical: anterior/posterior tonsilar Other: _____
Respiratory CTA other: _____
CV RRR murmur other _____
GI Benign (active BS/no masses/tenderness/hepatosplenomegaly) Other: _____
M/S: _____ FROM _____ N/V/S deficits Other: _____ CVA tenderness: Yes No _____
Skin: _____

PROVIDER SIGNATURE: _____

LABS ORDERED: _____

CALL RX TO: _____

FOLLOW UP: IF LOR YES NO _____ DAYS _____ WEEK(S) _____ MONTH(S) _____ PRN

Date: _____

Patient Name: _____ Patient DOB: _____

List previous surgical procedures.

Name of Procedure	Date of Procedure

List all current prescribed, over the counter medications, and herbal remedies.

Medication Name	Dosage	Frequency

List any allergies to medicine or dyes _____

List all other allergies _____

Do you currently use smokeless tobacco/cigarettes/cigars? Yes _____ No__

If yes, which one and quantity/day _____

Do you drink alcohol? Yes ___ No ___

If yes, indicate beverage and quantity/day _____

Daily caffeine intake: coffee ___ tea ___ soda ___

Date: _____

Patient Name: _____ Patient DOB: _____

Other Medical History:

Mark (x) if you are currently experiencing or recently experienced any of the following:

- | | | |
|--|--|--|
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Vision problems | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Heart palpitation | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Appetite problems |
| <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Joint pain/swelling | <input type="checkbox"/> Rashes on skin |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Immune problems | |

Have you ever been treated for any of the following? Mark (x) if Yes

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Vein/artery disease | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Stroke | <input type="checkbox"/> Elev. Cholesterol/triglycerides |
| <input type="checkbox"/> Cancer: (Type) _____ | | |

List Other Diseases: _____

Family History: Please indicate all conditions that apply to family members (brother, sister, father, mother, aunt, uncle, grandparent) and NOTE RELATIONSHIP or additional concerns below:

- | | |
|--|---|
| <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Thyroid disorder _____ |
| <input type="checkbox"/> Asthma/allergies _____ | <input type="checkbox"/> Heart disease _____ |
| <input type="checkbox"/> Headaches _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Chronic lung disease _____ |
| <input type="checkbox"/> Seizures/epilepsy _____ | <input type="checkbox"/> Alcoholism/substance abuse _____ |
| <input type="checkbox"/> Kidney problems _____ | <input type="checkbox"/> Bleeding/clotting disorder _____ |
| <input type="checkbox"/> High cholesterol _____ | <input type="checkbox"/> Ulcers _____ |
| <input type="checkbox"/> Mental illness _____ | <input type="checkbox"/> Cancer _____ |

Emergency Contact Information

Name: _____
Relationship: _____
Address: _____

Phone: _____

Patient Signature: _____ Date: _____