

PERRYTON HEALTH CENTER  
CONDITIONS OF ADMISSION & CONSENT FOR TREATMENT

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

CIVIL STATUS:    MINOR    SINGLE    MARRIED    DIVORCED    WIDOWED

Parent/Name Guardian: \_\_\_\_\_  
SSN#: \_\_\_\_\_ Race: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

**RESPONSIBLE PARTY (IF UNDER 18)-**

NAME: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SSN#: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_ CELLPHONE: \_\_\_\_\_

EMERGENCY CONTACT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PATIENT HISTORY

First: \_\_\_\_\_ Last: \_\_\_\_\_ Hand Dominance: o Right o Left  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_  
Who referred you to our clinic? \_\_\_\_\_

Do you see any other medical specialists (i.e. cardiologist, etc.)? If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Pharmacy name and address: \_\_\_\_\_

Current Medications/Dosages Taken: \_\_\_\_\_  
\_\_\_\_\_

Previous Surgeries/Dates: \_\_\_\_\_  
\_\_\_\_\_

Smoking History: Do you smoke? \_\_\_\_\_ How many pack/day? \_\_\_\_\_  
If so how long have you smoked? \_\_\_\_\_  
Former smokers how long ago did you quit? \_\_\_\_\_

Alcohol use: Nondrinker? \_\_\_\_\_  
Less than six drinks/week? \_\_\_\_\_ Six or more drinks a week? \_\_\_\_\_  
Type of Alcohol: \_\_\_\_\_

PERSONAL MEDICAL HISTORY

Have you ever had or do you now have: (check YES or NO)

	Yes	No		Yes	No
1. Shortness of Breath			21. Excessive Scarring/Keloid		
2. Asthma			22. Vomiting Blood/Black Stools		
3. Chronic Bronchitis			23. 25. Recent Gain or Loss in Weight		
4. Frequent Cold/Cough			24. Hemorrhoids		
5. Heart Disease			25. Hernia		
6. High or Low Blood Pressure			26. Kidney Trouble or Nephritis		
7. Heart Valve Probs/Murmurs			27. Painful or Bloody Urination		
8. Breast Problem/Disease			28. Low Back Trouble/Backache		
9. Back Pain			29. Varicose Veins		
10. Ankle Swelling			30. Blood Clots		
11. Easy Bruising			31. Radiation Therapy		
12. Excessive Bleeding			32. Epilepsy or Seizures		
13. Anemia or Blood Disease			33. Emotional/Psychiatric Problems		
14. Thyroid Disease			34. AIDS or HIV		
15. Rash			35. Facial Paralysis or Numbness		
16. Diabetes			36. Limited Activity		
17. Skin Cancer			37. Anesthesia Problems		
18. Arthritis/Joint Problems			38. Herpes or Fever Blisters		
19. Chronic Diarrhea/Bowel Trb.			39. Eating Disorder		
20. Hepatitis/Jaundice/Liver Trb.					