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

<table>
<thead>
<tr>
<th>NAD other:</th>
<th>M/S: A&amp;Ox3</th>
<th>PERLA</th>
<th>EOMI</th>
<th>Meningeal signs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood:</td>
<td>Affect:</td>
<td>Appropriate Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tympanic Membranes:</td>
<td>Intact</td>
<td>Perforated</td>
<td>+ Light Reflex</td>
<td>Red/Dull</td>
</tr>
<tr>
<td>Sinus:</td>
<td>Pain with Percussion</td>
<td>Yes</td>
<td>No</td>
<td>Nasal Mucous Membranes</td>
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<tr>
<td>Posterior Pharynx/tonsils:</td>
<td>Edema</td>
<td>Erythema</td>
<td>Exudate</td>
<td>Normal</td>
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<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck:</td>
<td>thyroidmegaly</td>
<td>Lymph Nodes:</td>
<td>No</td>
<td>Cervical:</td>
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<tr>
<td>Respiratory</td>
<td>CTA other:</td>
<td></td>
<td></td>
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<tr>
<td>CV</td>
<td>RRR</td>
<td>murmurmur</td>
<td>other</td>
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<tr>
<td>GI</td>
<td>Benign (active BS/no masses/tenderness/hepatosplenomegaly)</td>
<td>Other:</td>
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<td></td>
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<tr>
<td>M/S:</td>
<td>FROM</td>
<td>N/V/S deficits</td>
<td>Other:</td>
<td>CVA tenderness:</td>
</tr>
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</table>

Skin:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

PROVIDER SIGNATURE: ___________________________________________________________________

LABS ORDERED: ________________________________________________________________

CALL RX TO: ________________________________________________________________

FOLLOW UP: IF LOR YES NO _____ DAYS _____ WEEK(S) _____ MONTH(S) _____ PRN
List previous surgical procedures.

<table>
<thead>
<tr>
<th>Name of Procedure</th>
<th>Date of Procedure</th>
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List all current prescribed, over the counter medications, and herbal remedies.

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<tr>
<th>Medication Name</th>
<th>Dosage</th>
<th>Frequency</th>
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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 ____
Other Medical History:
Mark (x) if you are currently experiencing or recently experienced any of the following:

- Weight loss/gain
- Heart palpitation
- Blood in urine
- Headaches
- Anemia
- Vision problems
- Shortness of breath
- Joint pain/swelling
- Sleeping problems
- Immune problems
- Difficulty swallowing
- Appetite problems
- Rashes on skin
- Thyroid problems

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

- Heart disease
- Kidney disease
- Depression
- Migraine headaches
- Cancer: (Type)
- Vein/artery disease
- Liver disease
- Diabetes
- Stroke
- Chronic lung disease
- Seizures/epilepsy
- Alcoholism/substance abuse
- Kidney problems
- Bleeding/clotting disorder
- High cholesterol
- Ulcers
- Mental illness
- Thyroid disorder
- Heart disease
- Diabetes
- Chronic lung disease
- Alcoholism/substance abuse
- Bleeding/clotting disorder
- Ulcers
- Cancer

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:

- High blood pressure
- Thyroid disorder
- Heart disease
- Diabetes
- Chronic lung disease
- Alcoholism/substance abuse
- Bleeding/clotting disorder
- Ulcers
- Cancer

Emergency Contact Information

Name: ____________________________________________
Relationship: ______________________________________
Address: __________________________________________
Phone: ____________________________________________

Patient Signature: ____________________________ Date: ____________________________