Health Center Flow Sheet
Please complete while you are waiting to be seen-Thank you!

DATE: __________________ TIME: ____________ PHONE NUMBER: ________________________
LAST NAME ___________________________ FIRST NAME: ____________________________
EMAIL: ____________________________ Preferred Name (Nickname) ____________________________

Reason for visit today (brief)? All visits will be kept confidential unless written permission is given by you.

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**Health Promotion**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>I smoke cigarettes/ use tobacco products</td>
<td></td>
</tr>
<tr>
<td>I’m worried I may have a problem with alcohol or drugs</td>
<td></td>
</tr>
<tr>
<td>I would like information on birth control/sexually transmitted diseases</td>
<td></td>
</tr>
<tr>
<td>I would like information on gynecological exams or gardasil (HPV vaccine)</td>
<td></td>
</tr>
<tr>
<td>I am concerned I may be pregnant</td>
<td></td>
</tr>
<tr>
<td>I would like information on healthy diet and exercise</td>
<td></td>
</tr>
<tr>
<td>Have you felt afraid due to verbal or physical threats, touched in a sexual manner against your will or think you may be a victim of sexual violence?</td>
<td></td>
</tr>
</tbody>
</table>

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**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
- [ ] Sore throat
- [ ] Ear Pain
- [ ] High Blood Pressure
- [ ] Crying/ Mood swing
- [ ] Irregular menstrual cycle
- [ ] Back pain
- [ ] STD’S
- [ ] Headaches

- [ ] Additional Concerns: SPECIFY

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The Health Center believes that Health Care 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?

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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 speak with the health center staff. If my insurance has changed, I will give this information at the time of service.

Signature: ____________________________ Date: _____/_____/_______
HPI:____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

CURRENT MEDICATIONS: ____________________________

ALLERGIES: ____________________________

PEAK FLOW: ____________________________

VISION: R- 20/_____ L- 20/_____ 

PULSE: ____________________________

BP: ____________________________

WNL: ____________________________

ALERTER: ____________________________

HPI?: ____________________________

DATE: ____________________________

FT ATTLELITE? Y/  N: ____________________________

POLL? Y/  N: ____________________________

OFFICE USE ONLY

Premier Primary Care