PATIENT INFORMATION SHEET

Date:

Name: Date of Birth:
Social Security Number:
Permanent Address:
Telephone Number:
Person to be notified in case of emergency:
Address: Telephone Number:
Local Contact Person:
Address: Telephone Number:
Drug Allergies:
Patient History (serious illness/injury/surgeries):
Do you smoke? Yes Never Not Now
If yes, how many per day? If not now, when did you quit?
Family History:
High Blood Pressure:
Diabetes:
Cancer:
Other:
Current Medications:
Have you had: **Measles** Yes No **Mumps** Yes No **Chickenpox** Yes No
Have you ever been tested for tuberculosis? Yes No If Yes, How long ago?
Have you ever been vaccinated to prevent you from getting tuberculosis?(BCG) Yes No
Have you ever taken preventative tuberculosis medication? (INH) Yes No
Dates Updated:
BCCC College Health Services West Dorm 322-3371