SCOTT KEY CENTER
HELPING SHAPE FUTURES

ANNUAL HEALTH SUMMARY

ALL INFORMATION MUST BE COMPLETED. (Please Type or Print Clearly)

SECTION I – INDENTIFICATION

A. _____

LAST NAME FIRST NAME MIDDLE B. DATE OF BIRTH

C. _____

ADDRESS CITY/COUNTY STATE ZIP CODE

D. _____

TELEPHONE NUMBER E. RACE SEX MARITAL STATUS

SECTION II – HEALTH HISTORY OF PAST YEAR

X = YES

_____ Serious Head Injury
_____ Difficulty with vision
_____ Wears glasses
_____ Difficulty with breathing
_____ Wears hearing aid
_____ Frequent nose bleeds
_____ Ear infections
_____ Sore, bleeding gums
_____ Frequent sore throats
_____ Frequent colds
_____ Pneumonia/bronchitis
_____ Hernia
_____ Varicose/veins/ulcers
_____ Psychiatric disorder
_____ Unsteadiness in walking
_____ Unusual weight loss
_____ Other: (explain below)

_____ Diabetes
_____ Asthma
_____ Heart trouble
_____ High Blood Pressure
_____ Severe indigestion
_____ Frequent vomiting
_____ Constipation
_____ Bowel incontinence
_____ Urine incontinence
_____ Kidney disease
_____ Gynecology problems
_____ Venereal disease
_____ Arthritis
_____ Fractures of extremities
_____ Seizures
_____ Unusual weight gain

_____

_____

REMARKS: (GIVE DETAILS FOR ANY YES RESPONSE)

_____

_____

HOSPITALIZATIONS/OPERATIONS (DATES, REASONS, AND PLACE)

ACCIDENTS/INJURIES (DATES AND DESCRIPTION)

MEDICATIONS AND DOSAGES AT TIME OF PHYSICAL EXAMINATION:

MEDICATION	DOSAGE	PRESCRIBING PHYSICIAN

Signature & Title of Individual Completing Form

Date