SEVENTH-DAY ADVENTIST CHURCH
Lake Union Conference

OFFICE USE ONLY
DATE: _____ COUNTRY: USA
YYYY-MM-DD
CLINIC: _____

Patient Medical Record

Personal

LAST NAME	FIRST NAME	MI	☐ Male ☐ Female
ADDRESS	CITY	STATE	ZIP
EMAIL	PHONE	BIRTH DATE	AGE

Assessment

TRIAGE MUST CHECK THE FOLLOWING:	BP	TEMP	PULSE	RESP	REGULAR MEDICAL CARE? ☐ Yes ☐ No

VACCINATIONS
☐ Tetanus ☐ Measles ☐ Polio
☐ Diphth ☐ Rubella ☐ Mumps
☐ Other_____

DRUG ALLERGIES
☐ None ☐ Emycin ☐ Cephalosporin
☐ PCN ☐ Flagyl ☐ Fluoroquinolones
☐ Sulfa ☐ TCN/DCN ☐ Spectinomycin
☐ Other_____

LAST MEDICAL VISIT (WHEN AND WHY)

MEDICAL HISTORY
☐ Chicken Pox ☐ Seizures ☐ Heart Disease
☐ Malaria ☐ Tobacco Use ☐ Heart Valve
☐ Measles ☐ Vision Loss ☐ Hepatitis (Circle: A B C D E)
☐ Mumps ☐ Wears Glasses/Contacts ☐ High or Low BP
☐ Parasites ☐ Anemia ☐ HIV+
☐ Rheumatic Fever ☐ Arthritis ☐ Joint Replacement
☐ Scarlet Fever ☐ Asthma ☐ Leaky Heart Valve
☐ Hearing Loss ☐ Diabetes ☐ Tuberculosis
☐ Radiation TX ☐ Excessive Bleeding

CURRENT MEDICATIONS

FEMALES ONLY | LMP | PREGNANT? ☐ Yes ☐ No ☐ Possibly

Medical

REASON FOR VISIT

NOTES (Please write legibly)

SERIVCES PROVIDED
☐ Medical Exam
☐ Glucose Check
☐ Diabetic Education
☐ Health Education
☐ Other (Please list below)

PHYSICIAN'S SIGNATURE	PRINT NAME