GET WELL

GET WELL HOME HEALTH CARE SERVICE

CLIENT INFORMATION SHEET

PERSONAL INFRMATION

Name: ……

Age: …….. Case No: …….....

Address: ……

Sex: …… Marital status: ……

Weight: …….. Height: ……...

MEDICAL HISTORY

Present Medical Condition/s:

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Past medical Condition/s:

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SURGICAL HISTORY

Present surgical Condition/s:

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Past Surgical condition/s:

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MEDICATION

Is the client on any continuous treatment? **Yes/No**

Mode of Treatment:

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Medication he/she is currently on:

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History of allergy to medication/s **Yes/No**

State the Medication/s:

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PHYSICAL EXAMINATION

Appearance/Orientation:

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Head/Face/Neck:

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Chest/Abdomen/Back:

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Lungs:

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Heart:

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Limbs and extremities:

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Nerves:

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