Two Spirit Health Services
801 N. Magnolia Ave. Suite 402
Orlando Fl. 32803

Name:_____
Preferred Name:_____
Address:_____
_____
Birth date:_____
Telephone Number:_____

Primary Care Physician:_____
Health Insurance Carrier:_____
Member #:_____
Group #:_____

List prescriptions and non prescriptions you are currently taking:
_____
_____
Drug sensitivity and allergies:_____
_____

Have you ever been told you have the following? Please circle one:

High blood pressure	yes	no
Diabetes	yes	no
Suffer from seizures	yes	no
Hepatitis	yes	no
Heart trouble	yes	no
Lung disorder	yes	no
Nervous disorder	yes	no
Arthritis	yes	no
Kidney disorder	yes	no
Cancer	yes	no
Blood disorder	yes	no

Vision or hearing loss? (describe)_____
Any life-threatening conditions? (describe)_____
_____

Have you been hospitalized during the last year?
_____
_____
_____

Have you had any surgical procedures within the five years?
_____
_____
_____
Date of last physical:_____

Family history: (list important medical problems)

Mother:_____
_____
Father:_____
_____
Any other specific medical information:_____
_____