Intensive Outpatient Program
Behavioral Health Outpatient Services
Patient History

Patient Name: _____ Date: _____

DOB: _____ AGE: _____ SEX: ☐M ☐F

IMMUNIZATION HISTORY:

HAVE YOU HAD:

	YES	NO	DATE OF LAST
Hemophilus Influenza Vaccine (HIB)	☐	☐	_____
Pneumonia / Influenza Shot	☐	☐	_____
Measles & Mumps Shots	☐	☐	_____
Polio Vaccine	☐	☐	_____
Tetanus Shot	☐	☐	_____
Diphtheria Shot	☐	☐	_____
TB Skin Test (pos / neg)	☐	☐	_____
Hepatitis Shots	☐	☐	_____
Rubella Shot or Blood Test	☐	☐	_____

LIST ALL ALLERGIES: _____

COMMUNICABLE DISEASE SCREENING

Have you had any of the following?

1. Methicillin-resistant Staphylococcus aureus (**MRSA**) in the past 12 months?	☐ Yes	☐ No	☐ Unknown
2. Any other Multi-drug resistant organisms (**MDRO**) in the past 30 days?	☐ Yes	☐ No	☐ Unknown
3. Clostridium difficile (**C. diff**) in the past 30 days?	☐ Yes	☐ No	☐ Unknown
4. Diarrhea in the last 7 days?	☐ Yes	☐ No	☐ Unknown

Depending on the responses to the above questions, the provider reviewing this document may refer you for a follow-up appointment with your physician, nurse practitioner (NP), or physician's assistant (PA). At this appointment you should request written documentation that you pose no risk for exposing others to communicable diseases.

I acknowledge that the above information is true and correct to the best of my knowledge.

PATIENT SIGNATURE: **DATE:** **TIME:**

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

Patient Name:_____

DOB:_____

Or label

Name / MR # / Label