30 Eastern Ave • Suite 300 • Malden MA 02148 • Phone: 781-605-3724 Fax:321-445-4749

HEALTH HISTORY FORM

Client History / Medical Approval

Patience's Name: _____ D.O.B. : _____/_____/_____

MassHealth ID#: _____ MR#: _____

Address: _____

City: _____ State _____ Zip: _____ Phone: (_____) _____

MEDICAL DIAGNOSIS: ICD-10 CODES: _____

Diet: _____

Vaccinations:

TB Test Date and Finding: _____ Chest X-ray (if needed): _____

Flu (date): _____ Hepatitis B Vaccine (date): _____

Tetanus Toxoid (date): _____ HPV (date): _____

Other: _____

_____

Last Physical Exam (date): _____ Mammogram (last date) after age 40: _____

Pap Smear (date): _____ PSA Screening for Men (date): _____

Last Eye Exam: _____ Last Dental Exam: _____

Podiatrist (if indicated): _____ Psychiatric Eva: (if indicated): _____

Note to Doctors: Per MassHealth, in order to apply for the program, physical cannot be older than 1 year and last office visit cannot be older than 3 months. Please, provide patient's records for the last 3 visits.