Name_____ Date_____

E.M.R. Updated Information

Current Blood Pressure (taken by Staff)_____

What is your current smoking status? (Please Check)
Current every day Smoker _____ Current some day smoker_____
Former Smoker _____ How Long Ago did you Smoke_____
Never Smoked_____

Are you Diabetic ? (Please Circle) Yes No
Are you interested in Diabetic Shoes ? Yes No

Any Medical Problems in the past 2 years? If yes please write them below.
Yes No

_____

_____

Have you Fallen in the last 2 Years ? Yes No

What is your Current Height?_____ Weight?_____

Current
Medications:_____

_____

Can we request your List of Medications from your Pharmacy? YES NO

Allergies :_____

_____

Have you received your Flu Shot? Yes No When_____

Have you received your Pneumonia Shot? Yes No When _____

Signature of
Patient_____