-AFFORDABLE CARE HEALTH CLINIC

PATIENT HISTORY FORM

For the sake of patient confidentiality, information contained here will NOT be released to anyone without your written consent.

TODAY'S DATE: _____ LAST PHYSICAL EXAM: _____BY WHOM:_____ Height:_____ Weight:_____

LAST NAME: _____ FIRST NAME: _____

ETHNICITY: Asian African/African-American Caucasian Hispanic **OCCUPATION:_____**

Circle one: Married Domestic Partner Single Divorced **Number/ages of children: _____**

What brings you here today?_____

MEDICAL HISTORY (High Blood Pressure, Diabetes, Asthma, Cancer, Heart Disease, Thyroid Problems, etc.) **AND DATES OF ONSET:**

_____

_____

SURGICAL HISTORY (Tonsillectomy, Appendectomy, Hysterectomy, Hernia, etc.) **AND DATES**: □ NONE

_____

_____

ALLERGIES TO MEDICATIONS □ NONE (If YES, please list medication and explain type of reaction, i.e. hives, rash, wheezing, trouble breathing, swelling, upset stomach, itchy runny nose, watery eyes, etc.)

_____

Allergies to foods or the environment_____

CURRENT PRESCRIPTION/OVER THE COUNTER/HERBAL MEDICATIONS: Aspirin, Tylenol, Synthroid, Vitamins, St. John's Wort, etc.

MEDICATION	DOSAGE (MG/MCG/UNITS)	TIMES PER DAY	WHY DO YOU TAKE IT?	FOR HOW LONG?

FAMILY HISTORY

Father: □ Living, age: _____ □ Deceased, age at death: _____ (Cause) _____
Mother: □ Living, age: _____ □ Deceased, age at death: _____ (Cause) _____
Siblings: Number living: _____ Number deceased _____ (Cause) _____

FAMILY MEMBER ILLNESS List other illnesses in your parents/grandparents/siblings/children: (like diabetes, heart disease, high blood pressure, cancer, addiction or mental illness, etc.) and who has it.

_____

SOCIAL HISTORY

Do you exercise regularly? □ Yes / □ No If yes, what and how often?_____

Do you smoke? If yes, how much? ____ # of packs/day for_____ years. **If no**, when did you stop smoking? _____(CONGRATS!)

□ I am interested in quitting smoking (YOU CAN DO IT!) □ I have never smoked (EXCELLENT!)

Alcohol? If yes, how much? _____drinks every (circle) day week month year □ I am interested in quitting drinking

Other chemicals? If yes, what kind? (pot, coke, crack, etc.)_____ How often?_____

□ I am interested in talking to someone about my chemical dependency

REVIEW OF SYSTEMS

Do you now or have you had any problems related to the following symptoms? Check current if this is a problem now, check past if this has been a problem and is not currently, and check no if this has never been a problem for you.

SYMPTOM	Current	Past	No
Fever			
Chills			
Headaches			
Hair or nail changes			
Blurred vision			
Double vision			
Hay Fever			
Drug allergies			
Ear infection			
Hearing problems			
Sore throat			
Sinus problem			
Chest pain			
Varicose veins			
High blood pressure			
Swelling in legs			
Leg pain if walking			
Wheezing			
Frequent cough			
Shortness of breath			
Diarrhea			
Excessive hunger			
Excessive thirst			
Excessive urination			
Nausea/vomiting			
Indigestion/heartburn			
Constipation			
Abdominal pain			

SYMPTOM	Current	Past	No
Urine leakage problems			
Trouble starting urine stream			
Difficulty emptying bladder			
Erectile problems			
Skin rash			
Boils			
Skin tags			
Persistent itch			
Wound(s)			
Persistent pain			
Tremors			
Dizzy spells			
Numbness/tingling			
Swollen glands			
Bleeding tendencies			
Persistent tiredness			
Too hot or too cold			
Depressed			
Considered suicide			
Change in sex drive			
Satisfactory sex life **Y/N**			
WOMEN ONLY: Age at onset of period: _____			
Last menstrual period:_____ Regular? Y/N n/a			
Any possibility you're pregnant? Y/N			
Pregnancies:_____ Abortions/Miscarriages:_____			
Birth control method:_____			
Last Pap test:_____ Last mammogram:_____			
Postmenopausal bleeding? Y/N Hysterectomy? Y/N			

Do you have a living will?_____ Durable power of attorney for health care?_____(Please give us a copy.)

I certify that the information presented above is accurate to the best of my ability, and I understand that this information will be used to plan my health care, and will not be shared with anyone without my written consent.

Patient/Parent Name (Print)_____

Patient/Parent Signature_____Date_____