Desert Senita Community Health Center

Patient Medical History

Social Security #______________
Patient Name____ Medical Record #_____________

Address______________________________ Date of Birth_________ M / F_________ Marital Status_________________
City__________________ State_____ Zip______ Occupation/Employer____
Phone #:________________________________ Work Phone #:____
Insurance Name:__________________________ ID#_________________Group #___________Phone #:_________________

Hospital Admissions and Chronic illnesses:

Year	Illness or Operation	Year	Illness or Operation
________	________________________________	________	________________________________
________	________________________________	________	________________________________
________	________________________________	________	________________________________
________	________________________________	________	________________________________

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus/Td	___________	Hepatitis A	___________	PSA	___________	Dental	___________
Rectal/Stool	___________	TB Skin Test	___________	Colonoscopy	___________	Eye	___________
Influenza (flu)	___________	Hepatitis B	___________	Cholesterol	___________	Other	___________
Pneumonia	___________	Other	___________				

List all medications you are currently taking: *(Please include any over the counter medication, vitamins, or herbal supplements)*

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____
____

List Allergies:

____
____

Medical History: *(Please check all that apply)*

☐ Decreased hearing
☐ Ringing in ear
☐ Ear infections – frequent
☐ Dizzy spells ☐ Fainting spells
☐ Failing vision ☐ Eye pain
☐ Double or blurred vision
☐ Nose bleeds - recurrent
☐ Sinus trouble
☐ Sore throats - frequent
☐ Hoarseness - prolonged
☐ Hay fever / allergies
☐ Pneumonia / pleurisy
☐ Bronchitis / chronic cough
☐ Asthma / Wheezing
☐ Shortness of breath:
☐ On exertion ☐ Lying flat
☐ Chest pain
☐ Heart murmur ☐ Swollen ankles
☐ Irregular pulse ☐ Palpitations
☐ Leg pain - when walking
☐ Varicose veins / phlebitis
☐ Cold numb feet
☐ Loss of appetite
☐ Difficulty swallowing
☐ Heartburn ☐ Peptic ulcer
☐ Abdominal pain - chronic
☐ Gall bladder trouble
☐ Jaundice ☐ Cirrhosis
☐ Diarrhea ☐ Constipation
☐ Diverticulitis ☐ Crohn's / Colitis
☐ Bloody or tarry stools
☐ Hemorrhoids ☐ Hernia
☐ Victim of abuse

☐ Sexually transmitted diseases
☐ AIDS / HIV ☐ Herpes
☐ Weight-loss ☐ Weight-gain
☐ Anemia ☐ Bruise easily
☐ Blood transfusions
☐ Cancer ☐ Chronic fatigue
☐ Diabetes ☐ Thyroid disease
☐ Seizures ☐ Stroke
☐ Tremor / hands shaking
☐ Numbness / tingling sensations
☐ Headaches - frequent
☐ Arthritis / Rheumatism
☐ Back pain - recurrent
☐ Bone fracture / joint injury
☐ Osteoporosis
☐ Foot pain ☐ Gout
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Sleeping or concentration difficulty
☐ Depression ☐ Nervousness
☐ Agitation ☐ Memory loss
☐ Moodiness ☐ Suicidal thoughts
☐ Phobias ☐ Mental illness
☐ Feelings of worthlessness
☐ Rheumatic Fever ☐ Tuberculosis
☐ Chicken Pox ☐ Polio ☐ Mumps
☐ Measles ☐ German measles
☐ Hepatitis A, B, C or other

Urination Problems
☐ Overnight > than twice
☐ More than 8 times / 24 hours
☐ Urgency to urinate - with leakage
☐ Decrease in force / flow - painful

☐ Stress incontinence - urine leakage with exercise / movement
☐ Blood in urine ☐ Kidney stones
☐ Urine infections - frequent

Please fill in daily amount
☐ Alcohol ________ ☐ Coffee __________
☐ Smoking _______packs per day ____years years quit ______
☐ Exercise __________________________
☐ Street Drugs _______________________
☐ Tattoos ☐ Piercing
☐ Hair loss ☐ Progressive ☐ Recent

Females - Please complete

Menstrual flow:
☐ Reg ☐ Irreg ☐ Pain / Cramps
Days of flow ______ length of cycle_______
☐ Pain / bleeding during or after sex
Number of pregnancies:
☐ Pregnancies_____ ☐ Abortions _______
☐ Miscarriages_____ ☐ Live births_______
Birth control method:__________________
☐ Hot flashes
☐ Menopause onset_____________
☐ Date of last PAP test________________
☐ Normal ☐ Abnormal
☐ Breast exam
☐ Self breast exam teaching
Date of last Mammogram________________
☐ Normal ☐ Abnormal

Males - Please complete

☐ Last testicular exam ________________
☐ Self testicular exam teaching
☐ Penile discharge

Please fill out both sides of this form

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Family History: Place the relationship of the family member on the line to the right of the medical term.

1.	Epilepsy	_________	7.	Hay fever	_________	13.	Heart disease	_________	19.	Cancer (type)	________
2.	Migraine	_________	8.	Asthma	_________	14.	Stroke	_________	20.	Alzheimer's	________
3.	Mental illness	_________	9.	Anemia	_________	15.	Hypertension	_________	21.	Lupus	________
4.	Glaucoma	_________	10.	Bleeds easily	_________	16.	Cholesterol	_________	22.	Other	________
5.	Diabetes	_________	11.	Osteoporosis	_________	17.	Alcoholism	_________			
6.	Thyroid disease	_________	12.	Arthritis	_________	18.	Hepatitis	_________			

Please add any additional information that will help your provider with your medical treatment.

____
____
____

Please circle one

Do you have a Living Will? ....YES NO

Would you like information on Living Will? ....YES NO

Provider Signature__________________________Date__________

Provider Signature__________________________Date__________

Provider Signature__________________________Date__________

Patient Signature __________________________ Date_________ Provider Signature__________________________Date__________

Please fill out both sides of this form