STP CHC's Patient's General Health History Form

Serve the People Community Health Center

Patient's General Health History form

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Today's date: (MM/DD/YYYY)		Primary Care Provider's (PCP) Name:		PCP's phone #	
Patient's Last Name:		Patient's First Name:		Patient's Middle Initial:		Date of Birth: (MM/DD/YYYY)	
Primary Pharmacy's Name & phone #		Primary Pharmacy's Address:	

Medical History
(please circle your answers)

Does the patient have any medical condition / history? (YES) (NO)
*If yes, please circle the condition(s) the patient has

AIDS / HIV	Cerebral Palsy	Headaches	Respiratory disease
Anemia	Circulatory Problems	Heart Murmur	Rheumatic fever
Arthritis, Rheumatism	Congenital Heart Lesions	Heart Attack	Scarlet fever
Artificial Heart Valves	Cortisone treatments	Other Heart Problem	Shortness of breath
Artificial Joints, Pins	Cough that does not go away	Hemophilia	Skin rash
Autism	COPD	Hepatitis	Sleep Apnea
**Asthma If so, date of last asthma attack:____/______/______	Cough up blood	Hernia Repair	Stroke
	Damaged Heart Valves	High Blood Pressure	Swelling of feet or ankles
	Diabetes If so, what's your most recent A1c: ___________	High Cholesterol Levels	Thyroid Disorder
Back Problems		Kidney Disease	Tobacco habit (smoking)
Bleeding abnormally	Developmental Delay	Liver Disease	Tuberculosis
Chemical dependency	Down Syndrome	Multiple Sclerosis	Ulcer
Cancer If so, which type:	Epilepsy / Seizures	Mitral Valve Prolapse	Venereal disease (STI / STD)
	Eye Trauma	Pacemaker	Other: ___________________________
Chemotherapy	Fainting	Radiation treatment	
Blood Transfusion. If yes, what is the approximate date of the last blood transfusion: ___/____/____			

**if you are filling this out for your child and your child has asthma, is the asthma medication available in the school nurse's office? (YES) (NO)

What are your child's asthma triggers?	Dust	Pollen	Heat	Weather	Exercise	Other:

If you're filling this out for your child and your child has special needs, please list their special needs:

Ocular (Eye) History
(please circle your answers)

Does the patient have any eye condition? (YES) (NO)
*If yes, please circle the eye condition(s) the patient has

Cataract	Macular Degeneration	Eye trauma	Uveitis
Glaucoma	Eye Turn (Lazy Eye)	Retinal Detachment	Other:

Allergies
(please circle your answers)

Does the patient have allergies to medications or materials? (YES) (NO)
*If yes, please circle the allergies the patient has

Aspirin	Local Anesthetic	Iodine	Other: ______________________
Barbiturates (sleeping pills)	Penicillin	Latex	
Codeine	Sulfas	None. I do not have any allergies.	

Current Medications

Is the patient currently taking any medications? (YES) (NO)
This includes natural supplements, multivitamins, herbal supplements, and eye drops
If yes, please write down all the medications that the patient is currently taking

Name of medication	*Dose*	*Frequency*	*Name of medication*	*Dose*	*Frequency*
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

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Surgical History	Has the patient had any surgeries? (YES) (NO) *If yes, please write down the date(s) and type(s) of surgery(ies)*		
Date of Surgery	Type of Surgery	Date of Surgery	Type of Surgery
1.		4.	
2.		5.	
3.		6.	

Ocular (Eye) Surgical History	Has the patient had any eye surgery? (YES) (NO) *If yes, please circle which one(s)*					
Glaucoma	Cataract	Retinal Detachment	Retinal Injections	Retina Laser	Eyelid Surgery	Lasik

Family History	Does the patient have any first-degree family members that have been diagnosed with any of the below conditions? (YES) (NO) *If yes, please write down the family member and check off condition they have*											
Family Member (mother, father, daughter, son, sibling, grandparent)	Type 1 DM	Type 2 DM	High Blood Pressure	High Cholesterol	Heart Disease	Cancer	Alcoholism	Glaucoma	Macular Degeneration	Cataract	Eye Turn	Night Blindness

Hospitalization History	Has the patient ever been hospitalized? (YES) (NO) If yes, please write down the date and reason for the hospitalization. Approximate date is fine. Hospitalization = patient was admitted to the hospital and was there for more than 24 hours.		
Date (Month / Year)	Reason for hospitalization	Date (Month / Year)	Reason for hospitalization
1.		4.	
2.		5.	
3.		6.	

I understand that it is my responsibility to inform my doctor if I, or my minor children, ever have a change in health. I also understand the importance of a truthful health history and that my provider and their staff will rely on this information for treating me. By signing this form, I certify that to the best of my knowledge the above information is complete and correct.

Name of patient or person filling this form out	Relationship to Patient, if other than patient

Signature of Patient, Parent, Guardian, or Personal Representative	Date (mm/dd/yyyy)