Flathead Community Health Center
Patient Health History

Patient's name: _____ **Date of Birth:** _____

Allergies

Do you have any known drug, food or environmental allergies?	Yes	No

Please list any allergies below:

Past Medical History

Do you have or have you had any of the following medical conditions?		
Hypertension (high blood pressure)	Yes	No
Angina	Yes	No
Heart disease	Yes	No
Heart attack	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Pneumonia	Yes	No
Asthma	Yes	No
Emphysema or (COPD)	Yes	No
Bleeding disorder	Yes	No
Peptic ulcers (stomach/duodenal)	Yes	No
Kidney disease	Yes	No
Hepatitis	Yes	No
HIV	Yes	No
Cancer	Yes	No
Arthritis	Yes	No
Thyroid disease	Yes	No
Depression	Yes	No
Seizures	Yes	No
Other:		

OB GYN for women

Are you pregnant?	Yes	No
How many children have you had?		
Have you had a cesarean delivery?	Yes	No

CURRENT PRESCRIBED MEDICATIONS

Dose/ How often
Dose/ How often
Dose/ How often
Dose/ How often
Dose/ How often
Dose/ How often
Dose/ How often
Dose/ How often
Dose/ How often
Dose/ How often

CURRENT OVER THE COUNTER MEDICATIONS/SUPPLEMENTS

Dose/How often
Dose/How often
Dose/How often
Dose/How often
Dose/How often
Dose/How often
Dose/How often
Dose/How often
Dose/How often
Dose/How often

SOCIAL HISTORY

Do you exercise?	**Do you smoke?**
_____Yes _____No	_____Yes _____No

Do you drink alcohol?	**Do you consume caffeine?**
_____Yes _____No	_____Yes _____No

Are you feeling down, depressed or hopeless? _____Yes _____No

Do you have little interest or pleasure in doing things? _____Yes _____No

Patient's name: _____ **Date of Birth:** _____

Past Surgical Procedures

Please list any surgical procedures you may have had in the past, and your approximate age at the time.	
	Year
Hysterectomy	
Appendectomy	
Cholecystectomy (gall bladder surgery)	
Hernia repair	
Colon resection (section of the colon removed)	
Tonsillectomy	
Thyroid surgery	
Carotid artery surgery	
Heart bypass surgery	
Heart angioplasty	
Heart angioplasty with stent	
Kidney surgery	
Pacemaker	
Carpal tunnel surgery	
Knee arthroscopy	
Shoulder arthroscopy	
Spine surgery	
Joint replacement (indicate joint)	
Cataract surgery	
Prostate surgery	
Organ transplant (indicate organ)	
Colonoscopy	
Please list any other surgeries and approximate age.	

Please list the dates you had the following procedures.	
Last Colonoscopy	
Last PAP	
Last Mammogram	

Family History

Have any of your blood relatives (living or deceased) had any of the following?

M=Mother, F=Father, B= Brother, S= Sister, C=Child	
Hypertension (high blood pressure)	F M B S C
Heart disease	F M B S C
Stroke	F M B S C
Asthma	F M B S C
Diabetes	F M B S C
Thyroid disease	F M B S C
Tuberculosis	F M B S C
Hepatitis	F M B S C
Alcoholism	F M B S C
Depression	F M B S C
Alzheimer's disease	F M B S C
Cancer	F M B S C
Bleeding disorder	F M B S C
	F M B S C
	F M B S C
	F M B S C
	F M B S C
	F M B S C
	F M B S C
	F M B S C
	F M B S C

Immunization History:

Have you had immunizations?	_____Yes	_____No
Do you have a complete record available?	_____Yes	_____No
Have you had an adverse reaction?	_____Yes	_____No

Please list any hospitalizations and reason.