CHIRICAHUA COMMUNITY HEALTH CENTERS, INC.
HEALTH FOR ALL

Patient Medical History Form

(Please Print Clearly)

Patient Name _____ Date of Birth ___/___/___ Medical Record # _____

PAST MEDICAL HISTORY

Please complete the information below; if you have any questions, please do not hesitate to ask us.

MEDICAL

Type:	Check one:	Type:	Check one:	Type:	Check one:
Acne	❑ Yes ❑ No	COPD	❑ Yes ❑ No	Osteoporosis	❑ Yes ❑ No
ADD/ADHD	❑ Yes ❑ No	Coronary artery disease	❑ Yes ❑ No	Otitis	❑ Yes ❑ No
Allergies	❑ Yes ❑ No	Depression	❑ Yes ❑ No	PTSD	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Renal disease	❑ Yes ❑ No
Angina	❑ Yes ❑ No	Elevated lipids	❑ Yes ❑ No	Scoliosis	❑ Yes ❑ No
Anxiety	❑ Yes ❑ No	Gallbladder disease	❑ Yes ❑ No	Seizure disorder	❑ Yes ❑ No
Arthritis	❑ Yes ❑ No	GERD	❑ Yes ❑ No	SIDS	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Headache, Migraine	❑ Yes ❑ No	Strabismus	❑ Yes ❑ No
Atrial fibrillation	❑ Yes ❑ No	Heart disease	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Blood Clots	❑ Yes ❑ No	Heart valve disorder	❑ Yes ❑ No	Thyroid disease	❑ Yes ❑ No
Bronchitis	❑ Yes ❑ No	Hepatitis/liver disease	❑ Yes ❑ No	UTI	❑ Yes ❑ No
Cardiac arrhythmia	❑ Yes ❑ No	Hypertension	❑ Yes ❑ No	Auto Immune Disease:	
Concussion	❑ Yes ❑ No	Irritable bowel syndrome	❑ Yes ❑ No	Cancer:	
Constipation	❑ Yes ❑ No	Myocardial infraction	❑ Yes ❑ No	OTHER:	

SURGICAL

Type:	Check one:	Type:	Check one:	Type:	Check one:
Angioplasty	❑ Yes ❑ No	Carpal tunnel release	❑ Yes ❑ No	Joint replacement	
Appendectomy	❑ Yes ❑ No	Cataract extraction	❑ Yes ❑ No	Knee replacement	❑ Yes ❑ No
Back surgery	❑ Yes ❑ No	Cholecystectomy(gallbladder)	❑ Yes ❑ No	LASIK	❑ Yes ❑ No
Bilateral tubal ligation	❑ Yes ❑ No	Colectomy	❑ Yes ❑ No	Mastectomy	❑ Yes ❑ No
Blood transfusion	❑ Yes ❑ No	Colostomy	❑ Yes ❑ No	Myomectomy	❑ Yes ❑ No
Breast augmentation/Reduction	❑ Yes ❑ No	Dental surgery	❑ Yes ❑ No	ORIF	❑ Yes ❑ No
CABG	❑ Yes ❑ No	Gastric bypass/ Sleeve	❑ Yes ❑ No	Thyroidectomy	❑ Yes ❑ No
C-Section	❑ Yes ❑ No	Hernia repair/ umbilical	❑ Yes ❑ No	Tonsillectomy/ adenoids	❑ Yes ❑ No
Cardiac pacemaker	❑ Yes ❑ No	Hysterectomy/partial/complete	❑ Yes ❑ No	OTHER:	

Family Health History

Please only list only Mother, Father, Siblings, Grandparents and Immediate Aunts & Uncles. ☐ Adopted ☐ No Family History ☐ UNKNOWN

Type:	Relative:	Type:	Relative:	Type:	Relative:
ADD/ADHD		Depression		Mental illness	
Alcoholism		Developmental delay		Migraines	
Allergies		Diabetes		Obesity	
Alzheimer's disease		Eczema		Osteoporosis	
Arthritis		Elevated lipids		Peripheral vascular disease	
Asthma		Genetic disease		Renal disease	
Blood disorder		Hearing deficiency		Seizure disorder	
Cancer		Hypertension		Stroke	
Cardiovascular disease		Irritable bowel syndrome		Thyroid disorder	
Coronary artery disease		Learning disability			

ALLERGIES & REACTIONS

If allergic to any medications or food, please specify below

Medication/Food	Reaction

MEDICATIONS

Prefered Pharmacy Name: _____ Pharmacy Location: _____

Please list ALL medications along with units you are currently taking: *(example: Aspirin 25mg)*

Medication Name:	Units:	Medication Name:	Units:

OFFICE USE ONLY

Medical History Reviewed on: ____/____/____ MSS Printed Name: _____

Created: 12/05/2017-L.R.