CHS PATIENT HISTORY

Patient Name: _____ **Date of Birth _____**

Primary Language Spoken in Home _____ **Today's Date _____**

Personal Medical History:

- ☐None
- ☐Abd Pain
- ☐Acne
- ☐ADD
- ☐ADHD
- ☐Allergic Rhinitis
- ☐Allergies
- ☐Anemia
- ☐Angina
- ☐Anxiety
- ☐Arthritis
- ☐Asthma
- ☐Atrial Fibrillation
- ☐ Blood Clots/Bleeding Disorders
- ☐ Cancer; type:_____
- ☐ Chicken Pox
- ☐ Concussion/Closed Head Injury
- ☐ Congenital Heart Disease
- ☐ Constipation
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ CVA (stroke)
- ☐ Depression
- ☐ Diabetes
- ☐ Enlarged Prostate
- ☐ Eczema
- ☐ Fracture
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Headaches
- ☐ Hearing Problems
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irritable Bowel Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐Myocardial Infarction
- ☐Osteoarthritis
- ☐Osteoporosis
- ☐Peptic Ulcer Disease
- ☐Renal Disease
- ☐Seizure Disorder
- ☐Thyroid Disorder
- ☐UTI
- ☐Other _____
- ☐_____

Social History:

☐Tobacco Use
Type _____
Years of Use ____
How many packs per day? _____

☐ Illicit/Street Drug Use
Would you like information to stop? Y/N
Years of Use ____

☐ Alcohol
Drinks/week _____

Occupation:_____
Marital Status M S D W
# of children _____

Past Surgical History:	**Year**		**Year**		**Year**
☐None		☐ Gallbladder Removed	_____	**MALES ONLY**	
☐Adenoidectomy	_____	☐ Gastric Bypass/Gastric Sleeve/ Lap Band	_____	☐ Prostate Biopsy	_____
☐Angioplasty	_____	☐ Hernia Repair	_____	☐ TURP	_____
☐Angio with stent	_____	☐ Hip Replacement L or R	_____	☐ Vasectomy	_____
☐Appendectomy	_____	☐ Knee Replacement L or R	_____		
☐Arthroscopy knee: L or R	_____	☐ LASIK	_____	**FEMALES ONLY**	_____
☐Back Surgery	_____	☐ Liver Biopsy	_____	☐ Breast Biopsy	_____
☐CABG	_____	☐ ORIF (Fracture Repair)	_____	☐ C-Section	_____
☐Carpal Tunnel: L or R	_____	☐ Pacemaker	_____	☐ Hysterectomy	_____
☐Cataract Extraction	_____	☐ Small Bowel Resection	_____	☐ Tubal Ligation	_____
☐Colectomy	_____	☐ Thyroidectomy	_____	☐ Mastectomy L or R	_____
☐Colonoscopy	_____	☐ Tonsillectomy	_____	☐ Oophorectomy	_____
☐Colostomy	_____	☐ Other _____	_____	☐ Other	_____
☐Dental Surgery	_____	☐ Other _____	_____	☐ Other	_____

Family History: Circle M-mother, F-father, S-sister, B-brother O-other

☐Deceased	M	F	S	B	O _____	☐High Blood Pressure	M	F	S	B	O_____
☐ADD &/or ADHD	M	F	S	B	O _____	☐High Cholesterol	M	F	S	B	O_____
☐Alcoholism	M	F	S	B	O _____	☐Irritable Bowel Disease	M	F	S	B	O_____
☐Allergies	M	F	S	B	O _____	☐Learning Disability	M	F	S	B	O_____
☐Alzheimer's Dis	M	F	S	B	O _____	☐Mental Illness	M	F	S	B	O_____
☐Asthma	M	F	S	B	O _____	☐Migraine Headaches	M	F	S	B	O_____
☐Blood Disease	M	F	S	B	O _____	☐Obesity	M	F	S	B	O_____
☐Cancer; Type _____	M	F	S	B	O _____	☐Osteoarthritis	M	F	S	B	O_____
☐Coronary Artery Disease	M	F	S	B	O _____	☐Osteoporosis	M	F	S	B	O_____
☐CVA (stroke)	M	F	S	B	O _____	☐Peripheral Vascular Dis	M	F	S	B	O_____
☐Depression	M	F	S	B	O _____	☐Renal Disease	M	F	S	B	O_____
☐Developmental Delay	M	F	S	B	O _____	☐Seizure Disorder	M	F	S	B	O_____
☐Diabetes	M	F	S	B	O _____	☐Other: _____	M	F	S	B	O_____
☐Eczema	M	F	S	B	O _____	☐Other: _____	M	F	S	B	O_____
☐Hearing Deficiency	M	F	S	B	O _____	☐Other: _____	M	F	S	B	O_____

_____ _____ 12/16, 6/27/17

Provider Signature Date