

FT. WORTH NORTHSIDE COMMUNITY HEALTH CENTER, INC.

PATIENT HISTORY FORM

Name: _____ Height: _____ Weight: _____ DOB: _____ Date: _____

Please fill out the following information to help with your visit:

1. What brings you to the office? _____

2. Preferred Pharmacy: _____ Tel: _____ Fax: _____

3. Primary Care Physician: _____

4. Please check any **Health conditions** that you have:

- | | | |
|--|---|------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | Cancer of: _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anxiety | |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> HIV/Aids | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Bladder/Prostate | |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Stomach/Bowel problems | |

6. Please list any other health condition you may have: _____

7. Please check any **Surgeries** you may have had:

- | | | |
|--|--|---|
| <input type="checkbox"/> Ear Tubes | <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> C-Section |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Heart Stent | <input type="checkbox"/> Tubal Ligation |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Sinus Surgery | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Breast Biopsy | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Hernia | <input type="checkbox"/> Back |

Other Surgeries: _____

8. Please list all medications/vitamins / herbal medicines you currently take:

9. **LIST ALLERGIES:** _____

- Latex Allergy? Yes NO

Patient History [cont.]

TESTS [Give Date Last Done]

Test	Year Performed	Not Sure	Never Done	Results
Pap Smear				
Breast Exam				
Mammogram				
Rectal Exam				
Sigmoidoscopy				
Colonoscopy				
Cholesterol				
Rubella				
Triglycerides				
Thyroid Profile				
Tetanus [DPT]				
Bone Density				
PSA				
H & H				
Blood Sugar				

Menstrual Periods:

Age Onset: _____

Date of Last Period: _____

Periods: Regular Irregular Difficulty with Periods

Pregnancies:

of Children born alive _____

of Cesarean Sections: _____

of Premature Births: _____

of Stillborns: _____

of Miscarriages: _____

of Abortions: _____

Your Personal Habits: Do You?

Do you exercise regularly [3-4 x a week]? Yes No

Do you use Illegal Drugs? Yes No

Do you drink Alcoholic beverages? Yes No If "yes" How much: _____

Do you smoke? Yes No If "yes" how much? _____

Do you dip or chew tobacco? Yes No

How many glasses of caffeinated drinks do you consume a day? _____ Non-caffeinated drinks? _____

Do you have an eating disorder? Yes No Anorexia Bulimia

Have you been physically abused? Yes No

Do you feel safe in your home? Yes No

My signature indicates that the above information is true and correct to the best of my knowledge.

Signature: _____ DOB: _____ Date: _____

Patient Signature