DESERT SENITA
COMMUNITY HEALTH CENTER
Quality, Local, Affordable Health Care for All

Social Security #_____
Patient Name_____ Medical Record #_____
Address_____ Date of Birth_____ M / F_____ Marital Status_____
City_____ State_____ Zip_____ Occupation/Employer_____
Phone #:_____ Work Phone #:_____
Insurance Name: _____ ID#_____Group #_____Phone #:_____

Hospital Admissions and Chronic illnesses:

Year	Illness or Operation	Year	Illness or Operation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vaccine	Year of Last	Vaccine	Year of Last	Test/Exam	Year of Last	Test/Exam	Year of Last
Tetanus/Td	_____	Hepatitis A	_____	PSA	_____	Dental	_____
Rectal/Stool	_____	TB Skin Test	_____	Colonoscopy	_____	Eye	_____
Influenza (flu)	_____	Hepatitis B	_____	Cholesterol	_____	Other	_____
Pneumonia	_____	Other	_____				

List all medications you are currently taking: *(Please include any over the counter medication, vitamins, or herbal supplements)*

_____
_____
_____

List Allergies:

_____
_____
_____

Medical History: *(Please check all that apply)*

☐ Decreased hearing
☐ Ringing in ear
☐ Ear infections – frequent
☐ Dizzy spells ☐ Fainting spells
☐ Failing vision ☐ Eye pain
☐ Double or blurred vision
☐ Nose bleeds - recurrent
☐ Sinus trouble
☐ Sore throats - frequent
☐ Hoarseness - prolonged
☐ Hay fever / allergies
☐ Pneumonia / pleurisy
☐ Bronchitis / chronic cough
☐ Asthma / Wheezing
☐ Shortness of breath:
☐ On exertion ☐ Lying flat
☐ Chest pain
☐ Heart murmur ☐ Swollen ankles
☐ Irregular pulse ☐ Palpitations
☐ Leg pain - when walking
☐ Varicose veins / phlebitis
☐ Cold numb feet
☐ Loss of appetite

☐ Sexually transmitted diseases
☐ AIDS / HIV ☐ Herpes
☐ Weight-loss ☐ Weight-gain
☐ Anemia ☐ Bruise easily
☐ Blood transfusions
☐ Cancer ☐ Chronic fatigue
☐ Diabetes ☐ Thyroid disease
☐ Seizures ☐ Stroke
☐ Tremor / hands shaking
☐ Numbness / tingling sensations
☐ Headaches – frequent
☐ Arthritis / Rheumatism
☐ Back pain – recurrent
☐ Bone fracture / joint injury
☐ Osteoporosis
☐ Foot pain ☐ Gout
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Sleeping or concentration difficulty
☐ Depression ☐ Nervousness
☐ Agitation ☐ Memory loss
☐ Moodiness ☐ Suicidal thoughts
☐ Phobias ☐ Mental illness

☐ Stress incontinence - urine leakage with exercise / movement
☐ Blood in urine ☐ Kidney stones
☐ Urine infections – frequent
Please fill in daily amount
☐ Alcohol _____☐ Coffee _____
☐ Smoking _____packs per day ____years years quit _____
☐ Exercise _____
☐ Street Drugs _____
☐ Tattoos ☐ Piercing
☐ Hair loss ☐ Progressive ☐ Recent
Females - Please complete
Menstrual flow:
☐ Reg ☐ Irreg ☐ Pain / Cramps
Days of flow _____ length of cycle_____
☐ Pain / bleeding during or after sex
Number of pregnancies:
☐ Pregnancies_____ ☐ Abortions _____
☐ Miscarriages_____ ☐ Live births_____
Birth control method:_____
☐ Hot flashes
☐ Menopause onset_____

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☐ Difficulty swallowing
☐ Heartburn ☐ Peptic ulcer
☐ Abdominal pain - chronic
☐ Gall bladder trouble
☐ Jaundice ☐ Cirrhosis
☐ Diarrhea ☐ Constipation
☐ Diverticulitis ☐ Crohn's / Colitis
☐ Bloody or tarry stools
☐ Hemorrhoids ☐ Hernia
☐ Victim of abuse

☐ Feelings of worthlessness
☐ Rheumatic Fever ☐ Tuberculosis
☐ Chicken Pox ☐ Polio ☐ Mumps
☐ Measles ☐ German measles
☐ Hepatitis A, B, C or other

Urination Problems

☐ Overnight > than twice
☐ More than 8 times / 24 hours
☐ Urgency to urinate - with leakage
☐ Decrease in force / flow - painful

☐ Date of last PAP test_____
☐ Normal ☐ Abnormal
☐ Breast exam
☐ Self breast exam teaching
Date of last Mammogram_____
☐ Normal ☐ Abnormal
Males - Please complete
☐ Last testicular exam _____
☐ Self testicular exam teaching
☐ Penile discharge

Family History: Place the relationship of the family member on the line to the right of the medical term.

1. Epilepsy	_____	7. Hay fever	_____	13. Heart disease	_____	19. Cancer(type)	_____
2. Migraine	_____	8. Asthma	_____	14. Stroke	_____	20. Alzheimer's	_____
3. Mental Illness	_____	9. Anemia	_____	15. Hypertension	_____	21. Lupus	_____
4. Glaucoma	_____	10. Bleeds easily	_____	16. Cholesterol	_____	22. Other	_____
5. Diabetes	_____	11. Osteoporosis	_____	17. Alcoholism	_____		
6. Thyroid disease	_____	12. Arthritis	_____	18. Hepatitis	_____		

Please add any additional information that will help your provider with your medical treatment.

_____
_____
_____

Please circle one
Do you have a Living Will? .....YES NO
Would you like information on Living Will? .....YES NO

Provider Signature_____Date_____

Provider Signature_____Date_____

Provider Signature_____Date_____

Patient Signature _____ Date_____

Provider Signature_____Date_____