Community Health Center
of the North Country

HEALTH HISTORY FORM

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Address:		
Phone Number:	**Occupation:**	
Emergency contact (Name & Number):		
Parent/Guardian name:	**E-mail address:**	
Do you have an advanced directive or living will? ☐Yes ☐No		

MEDICAL HISTORY

Check if you have, or have had, of the following (check all that apply):

☐ Lung Disease	☐ Stroke	☐ Hip replacement	☐
☐ Asthma	☐ High/Low Blood Pressure	☐ Knee replacement	☐
☐ COPD/Emphysema	☐ Rheumatic Fever	☐ Anemia	☐
☐ Heart Disease	☐ Valve replacement	☐ Kidney Disease	☐
☐ Bladder Infections	☐ Migraines	☐ Bleeding Disorder	☐
☐ Diabetes	☐ Seizures	☐ Chronic Pain	☐
☐ Cancer	☐ Cerebral Palsy	☐ Epilepsy	☐
☐ Ulcers/Reflux	☐ Arthritis	☐ Depression	☐
☐ Thyroid Disease	☐ Drug addiction	☐ Alcohol addiction	☐
☐ Radiation Treatment	☐ Pace Maker	☐ Peripheral Vascular Disease	☐

Other Illnesses not listed: _____

_____

_____

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Are you currently Pregnant? ☐Yes ☐No

List your prescribed drugs, and over-the-counter drugs, including vitamins and herbal supplements below:		

Do you have any Allergies: ☐Yes ☐No

Allergy	Reaction You Had

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	Number of cups/cans per day?			
Alcohol	Do you drink alcohol?			☐ Yes ☐ No
	How many drinks per week?			
Tobacco	Do you use tobacco?			☐ Yes ☐ No
	☐ Cigarettes – pks./day_____	☐ Chew - #/day____	☐ Pipe - #/day_____	☐ Cigars - #/day_____
	_____ # of years	Or year quit:_____		

FAMILY HEALTH HISTORY

Please check if anyone in your family has any of the following illnesses. ***If yes, please indicate who.***

☐ Lung Disease	☐ Rheumatic fever	☐ Migraines
☐ Asthma	☐ Anemia/blood disorder	☐ Seizures/Epilepsy
☐ COPD/Emphysema	☐ Kidney Stones	☐ Cancer
☐ Heart Disease	☐ Mental Illness	☐ Depression
☐ Arthritis	☐ Ulcers/Reflex	☐ Thyroid Disease
☐ Alcohol Addiction	☐ Drug Addiction	☐ Suicide
☐ Diabetes	☐ High Cholesterol	☐

Other Medical Conditions/Illnesses not listed: _____

_____

_____

Patient or Guardian Signature:_____Date:_____