New Patient Health History Form

COMCARE
comprehensive family health care
Salina Regional Health Center

Name (Last, First MI):	**Today's Date:**
	Date of Birth:

Present Health Concerns:

Personal Medical History: Please indicate whether you have had any of the following medical problems (with approximate date of illness or diagnosis.

□ Blood Clots	□ Asthma	□ High Blood Pressure
□ Cancer	□ Hearing Loss	□ Migraine Headaches
Type:	□ Heart Problems	□ Stroke
Date:	□ Valvular (mitral/aortic)	□ Thyroid Problems
□ Concussion	□ Rhythm (a-fib)	
□ Depression	□ Blockage (heart attack)	□ Other:
□ Diabetes	□ Other:	
□ Type I		
□ Type II	□ High Cholesterol	

Surgical History: (Please list all other prior operations and dates)

Operation	Date	Operation	Date

Procedure History: (Please list all prior procedures and dates, i.e.. Colonoscopy, bone density scan, heart cath, stress test)

Procedure	Date	Procedure	Date

Women's Gynecologic History:

# of Pregnancies:	# of Deliveries:	# of Abortions:	# of Miscarriages:
1st Day of most recent period:	Age at 1st Period:	Frequency of periods:	Length of each:
Last Pap Smear:_____ Abnormal: □ Yes □ No		Last Mammogram:_____ Abnormal: □ Yes □ No	

Over →

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FAMILY HISTORY:

Relative	Year of Birth	Age of Death	Cause of Death	Health Issues (diabetes, high blood pressure, depression, cancer, etc.)
Father				
Mother				

Siblings (Please circle one)

Brother / Sister				
Brother / Sister				
Brother / Sister				
Maternal Grandmother / Grandfather				
Paternal Grandmother / Grandfather				
Other				

Social History:

Occupation:	Martial Status (circle one) Sgl / Mar / Wid / Div
Advanced Directives: □ DNR □ Living Will □ Power of Atty. Living Arrangements: □	Alcohol: □ Never □ Occasional □ Daily □ Prior Use □ Quit Date:_____
Caffeine Intake: □ Never □ Occasional □ Daily	□ Amount per week:_____
Tobacco: □ Current - Type:_____ Freq:_____ □ 2nd Hand □ Never □ Prior Use □ Quit Date_____	Drug Abuse: □ Never □ Occasional □ Daily □ Prior Use □ Quit Date: _____ □ Type of drug:_____

Medications:

Prescriptions and non-prescriptions medicines, vitamins, home remedies, birth control pills, herbs. If more space is needed you can attach a list. **BRING ALL OF YOUR MEDICATIONS TO YOUR FIRST APPOINTMENT.**

Medication	Dose	Times per Day	Prescribed by:

Allergies or Reactions to Medicines/Food/Other Agents: □ Check if no allergies

MEDICATION	Reaction or Side Effect

Immunizations: PLEASE BRING A COPY OF YOUR IMMUNIZATIONS TO YOUR FIRST APPOINTMENT.