Chico Immediate Care, Inc.
Comprehensive Health History

Name:	Birth date:	Today's Date:

General

Place of birth	Education	Date of last Eye exam	Date of last flu shot	Date of last Pneumovax
Relationship status	Occupation	Date of last Dental Exam	Date of last Mammogram	Date of last Colonoscopy
Who is your Primary Care Provider:		Date of last PAP or Prostate exam	Date of last Bone Density testing	

List all serious illnesses and/or hospitalizations you have experienced and indicate year these occurred: ☐ None	Vaccinations/Date		
	Pertussis/	Hepatitis A/	Shingles/
	Tetanus /	Hepatitis B/	Gardisil/
➢	List all significant surgeries, injuries, or fractures you have experienced and the year these occurred: ☐ None		
➢	➢		
➢	➢		
➢	➢		
➢	➢		
➢	➢		
➢	➢		
➢			

Prescription Medications (Include everything you have recently taken or are taking now, including dose/frequency) ☐ None

OTC MEDICATIONS and VITAMINS ☐ None

MEDICATION OR OTHER ALLERGIES ☐ None

Drug Allergies		Other Allergies, i.e. food, plants, iodine, etc
Name	What Reaction?	

Lifestyle

Tobacco ☐ None ☐ Former user ☐ Cigarettes ☐ Cigars ☐ Chew

How much? ☐ Rarely ☐ Occasional ☐ Light Regular ☐ Moderate Regular ☐ Heavy Regular

Amount per day? For how many years?

Caffeine

How much? ☐ None ☐ Rarely ☐ Occasional ☐ Regular ☐ Heavy

☐ Coffee ☐ Tea ☐ Carbonated Beverages ☐ Workout drinks Servings per day?

Alcohol

How much? ☐ None ☐ Rarely ☐ Occasional ☐ Light ☐ Moderate ☐ Heavy

Amount per day?

Diet
☐ Very healthy
☐ Sort of healthy
☐ Not so healthy

Exercise

How Often?
____days per week

How Long?
____min per session

Chico Immediate Care, Inc.
Comprehensive Health History

Your Current/Past Medical Conditions

Condition			Status & Notes	Condition			Status & Notes
Alcohol Abuse	Yes	No		Kidney Disease	Yes	No	
Anemia	Yes	No		Lung disease	Yes	No	
Arrythmia	Yes	No		Menopause	Yes	No	
Asthma	Yes	No		Myocardial Infarction/Angina	Yes	No	
Blood Transfusions	Yes	No		Osteoarthritis	Yes	No	
Cancer	Yes	No		Liver Disease	Yes	No	
Type:							
Depression	Yes	No		Psychiatric Illness	Yes	No	
Diabetes	Yes	No		Rheumatic Fever	Yes	No	
Drug Abuse	Yes	No		Rheumatoid Arthritis	Yes	No	
Epilepsy	Yes	No		Sleep Apnea	Yes	No	
Fibromyalgia	Yes	No		Stroke	Yes	No	
Gallstones	Yes	No		Thyroid disease	Yes	No	
Gout	Yes	No		Sexually Transmitted Disease	Yes	No	
Glaucoma	Yes	No		OTHER: please list	Yes	No	
Heartburn	Yes	No			Yes	No	
Hepatitis	Yes	No			Yes	No	
High Cholesterol	Yes	No			Yes	No	

Family Medical History

	WHO		WHO
Alzheimer's Disease		High Cholesterol	
Alcohol or Drug Problem		Kidney Disease	
Anemia		Mental Illness	
Asthma		Overweight/Obesity	
Autoimmune disorders		Osteoporosis	
Cancer – type?		Parkinson's	
Diabetes		Psoriasis	
Epilepsy		Rheumatoid Arthritis	
Glaucoma		Thyroid Disease	
Heart Disease		Other	
High Blood Pressure			

Current Status of Relatives

	Present age /or Age of death	If living, health (good, fair, poor)	If deceased, cause of death
Father			
Mother			
Siblings			
Children			

The Electronic Health Record has the capacity to allow us to immediately send prescriptions to your pharmacy of record and receive email prescription requests from them. As part of the system we can also 'acquire' your current, complete medication list from the pharmacy and place it directly into your medical record. This is one of the features of EMR systems that will improve patient care by improving information shared by your doctor and the other medical professionals that you receive care from.

May we acquire your medication list from pharmacies where you receive medications? ☐ Yes ☐ No