

**YAVAPAI COUNTY COMMUNITY HEALTH SERVICES  
MEDICAL HISTORY DATA Page 1**

**Date:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

Place Label Here

**First Name:** \_\_\_\_\_

**Medications**

Please list **ALL** medications that you are currently taking. (Prescriptions, over-the-counter and herbs)


**Allergies**

Please list all allergies to medications

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**Surgeries / Hospitalizations**

Please list hospitalizations/surgeries, including dates and reason.


**Patient History of Disease**

Please check the box on the left YES / NO and circle the condition.

YES	NO	Do you have or have you ever had...?	YEAR
		1. Anemia	
		2. Bladder problems: <span style="float: right;">Kidney problems:</span>	
		3. Cancer <span style="float: right;"><b>LOCATION:</b></span>	
		4. Depression / Mental illness / Anxiety	
		5. Diabetes	
		6. Epilepsy / Seizures / Headaches	
		7. Gallbladder disease	
		8. Heart disease	
		9. High cholesterol	
		10. Hypertension (High Blood Pressure)	
		11. Liver disease / Hepatitis	
		12. Lung disease / Asthma / TB / COPD / Emphysema / Other:	
		13. Stomach problems / Intestinal problems:	
		14. Stroke	
		15. Heart Attack	
		16. Thyroid disease	
		17. Arthritis / Back problems	
		18. Chronic pain symptoms:	
		19. Have you ever had a sexually transmitted disease: Chlamydia / Herpes / Syphilis/ Gonorrhea / Other:	

**Family History**

Please circle if your birth mother, father, sister or brother, daughter, son has or had ...

Diabetes? Mother, Father, Sister, Brother, Daughter, Son	Cancer? What type? Mother, Father, Sister, Brother, Daughter, Son
Hypertension/High Cholesterol? Mother, Father, Sister, Brother, Daughter, Son	Stroke or heart attack before age 50? Mother, Father, Sister, Brother, Daughter, Son
Lung disease (Asthma, TB, other)? Mother, Father, Sister, Brother, Daughter, Son	Other medical conditions? Mother <span style="float: right;">Brother</span> Father <span style="float: right;">Daughter</span> Sister <span style="float: right;">Son</span>
Thyroid disease? Mother, Father, Sister, Brother, Daughter, Son	<div style="text-align: right;"> </div>

**YAVAPAI COUNTY COMMUNITY HEALTH SERVICES  
MEDICAL HISTORY DATA- Page 2**

**Social History**

	Yes	No	QUIT	YEAR
Do you smoke cigarettes?				
If so, how many per day?				
Do you chew tobacco?				
If so, how much per day?				
Do you use alcohol?				
If yes, how much?				
Do you use street drugs?				
Do you exercise regularly?				
Do you feel safe in your home?				
What is your primary language?				

**Women ONLY**

What was the first day of your last menstrual period?	Date:	
When was your last Mammogram?	Date:	
When was your last pap smear?	Date:	
Have you ever had an abnormal pap smear?	Yes	No
List any problems you have with your <u>period</u> or with <u>menopause</u> :		
Is this your first pelvic exam?	Yes	No
Have you ever been pregnant? If yes, how many times?	Yes	No
Have you breastfed? How long?	Yes	No
Were there any problems during the pregnancy? (If yes, please explain)	Yes	No
Were there any problems during the delivery? (If yes, please explain)	Yes	No
Are you or your partner using a method of birth control? If yes, which method?	Yes	No
Do you have any vaginal changes that cause odor, itching, or burning?	Yes	No

**Under 18 years of age**

Are your parents invited to participate in your care?	Yes	No
Has anyone ever forced you to have sex?	Yes	No

<b>Patient Signature:</b>	<b>Date:</b>
<b>Parent or Guardian Signature:</b>	<b>Date:</b>

Place Label Here

