FOR CLINIC USE ONLY: WT_____ HT_____ TEMP_____ PULSE_____ O2_____ RESP_____ B/P_____

BRICKIE COMMUNITY HEALTH CLINIC

COMMUNITY CARE NETWORK
Community Healthcare System®

Date:_____
Patient Name:_____
Date of Birth:_____
Reason for visit:_____
_____

Primary Care Provider:_____

FEMALES ONLY: *Date of last menstrual period:_____ Could you be pregnant?_____*
Number of Pregnancies:_____ Number of births:_____

CURRENT SYMPTOMS:
PAIN?_____ WHERE?_____

Change in Appetite?	NO	YES	Dizziness or fainting?	NO	YES
Weight gain/loss:	NO	YES	Anxiety or depression?	NO	YES
Activity or sleep change?	NO	YES	Frequent or painful urination?	NO	YES
Headache?	NO	YES	Constipation?	NO	YES
Congestion or facial pain?	NO	YES	Diarrhea?	NO	YES
Sore throat or trouble swallowing?	NO	YES	Unusual bleeding?	NO	YES
Earache? Right or Left?	NO	YES	Rash or skin problems?	NO	YES
Cough? Productive?	NO	YES	Itching?	NO	YES
Shortness of breath or wheezing?	NO	YES	Wounds or sores?	NO	YES
Fast heartbeat?	NO	YES	Joint pain or swelling?	NO	YES
Chest pain?	NO	YES			

PAST HISTORY

Allergies	NO YES	Depression	NO YES
Anemia	NO YES	Diabetes mellitus	NO YES
Anxiety	NO YES	Emphysema	NO YES
Arthritis	NO YES	GERD	NO YES
Asthma	NO YES	Glaucoma	NO YES
ADD/ADHD	NO YES	Heart murmur	NO YES
Blood Transfusion	NO YES	HIV/AIDS	NO YES
Cancer	NO YES	High Cholesterol	NO YES
Cataracts	NO YES	High Blood Pressure	NO YES
Chicken Pox	NO YES	Kidney disease	NO YES
CHF	NO YES	Meningitis	NO YES
Clotting disorder	NO YES	Nerve/Muscle Disease	NO YES
COPD	NO YES	Seizures	NO YES
Osteoporosis	NO YES	Strep Throat (recurrent)	NO YES
Scoliosis	NO YES	Stroke	NO YES
Substance Abuse	NO YES	Thyroid Disease	NO YES
Tuberculosis	NO YES		

HOSPITALIZATIONS OR SURGERIES

_____
_____
_____

Do you Smoke? _____
If yes, packs daily?_____
How long?_____ **When stopped?**_____

Do you drink alcohol? NO YES
Type/amount per week: _____

In the last year, have you had any of the following?
Physical Exam:_____ Eye Exam:_____

In the last year, have you had any of the following vaccine?
Tetanus:____ Pneumonia:_____
Hepatitis B:_____ Flu Shot:_____ TB Test:_____
MMR:_____

ADULTS ONLY (18 & OVER)
Rectal/Prostate Exam:_____ Colonoscopy:_____
Mammogram:_____ Bone Density:_____ Pap Smear: _____

Any other concerns you would like to talk about today?_____

_____

_____

DRUG ALLERGIES

_____ _____

_____ _____

_____ _____

	Father	Mother	Mother's Mother	Mother's Father	Father's Mother	Father's Father	Siblings	Children
Alzheimer's/Dementia								
Arthritis								
Asthma								
Bleeding Disorder								
Cancer								
COPD/Emphysema								
Diabetes								
Epilepsy/Convulsion								
Glaucoma								
Heart Disease								
High Blood Pressure								
High Cholesterol								
Kidney Disease								
Mental Illness								
Stroke								
Thyroid Disease								
Other								

Names of Brothers	Age
Names of Sisters	Age

Your Preferred Pharmacy:_____ **Location**:_____

(Example—CVS) (Example—Lake Park Ave., Hobart)

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING & THOSE USED AS NEEDED (OTC & SUPPLEMENTS INCLUDED)

NAME OF MEDICATION	DOSAGE	FREQUENCY