LUCAS COUNTY HEALTH CENTER

An Affiliate of UnityPoint Health

CHARITON CLINIC

Patient Information Sheet

Patient Information

Last Name: _____ First Name: _____

Preferred or Nickname: _____ Maiden Name: _____

Date of Birth: _____ Gender: _____ Social Security #: _____

Race: _____ Ethnicity:_____ Marital Status (circle): M S D W

Primary Language used, if not English: _____

Address: _____

City, State, Zip: _____ County: _____

Home Phone: (_____) _____-_____ Alternate Phone: (_____) _____-_____

Primary Phone (circle): Home Alternate

Email Address: _____

Preferred Provider: _____ Preferred Pharmacy: _____

Employer: _____ Occupation: _____

Employer Address: _____

City, State, Zip: _____ Hire Date: _____

Status (circle): Full-time Part-time Phone: (_____) _____-_____ Extension: _____

Responsibility Billing Party (if different than above)

Name: _____ Phone: (_____) _____-_____

Address: _____

City, State, Zip: _____

Social Security #: _____ Date of Birth: _____

Relationship to Patient (circle one): Patient Spouse Mother Father Guardian

Signature: _____ **Date:** _____

A copy of your driver's license and insurance card is required at the time of registration.

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Health History Form – Past Personal Medical History

Problem:	Age:	Problem:	Age:
☐ Acid Reflux Disease/Heartburn/GERD		☐ Heart Attack/Coronary Artery Disease	
☐ Alcohol Abuse		☐ Heart Murmur	
☐ Allergic Rhinitis/Hay fever		☐ Hearting Loss	
☐ Alzheimer's Disease		☐ Hemorrhoids	
☐ Anemia		☐ Hepatitis	
☐ Angina/Chest Pain		☐ High Blood Pressure/Hypertension	
☐ Anxiety or Panic Disorder		☐ Hoarseness	
☐ Asthma		☐ Hyperlipidemia/High Cholesterol or Triglycerides	
☐ Atrial Fibrillation		☐ Hyperthyroidism/Grave's Disease	
☐ Attention Deficit Disorder (ADD or ADHD)		☐ Hypothyroidism (Low Thyroid Function)	
☐ Benign Prostate Enlargement (BPH)		☐ Insomnia	
☐ Bipolar Disorder		☐ Irritable Bowel Syndrome	
☐ Blindness		☐ Kidney Failure/Chronic Kidney Disease	
☐ Blood Clots/Phlebitis/Deep Vein		☐ Kidney Stones/Ureteral Stones	
☐ Blood in Stool		☐ Loss of Consciousness/Syncope	
☐ Blood in Urine		☐ Macular Degeneration	
☐ Cancer Site/Type: _____		☐ Osteoporosis	
☐ Chronic Bronchitis		☐ Other Thyroid Disease:	
☐ Chronic or Recurrent Back Pain		☐ Palpitations (Irregular Heart Beat)	
☐ Chronic Pain Syndrome		☐ Peptic Ulcer Disease (Stomach or Duodenal Ulcer)	
☐ Congestive Heart Failure		☐ Pneumonia	
☐ Constipation		☐ Prostate Cancer	
☐ Cough (Persistent or Recurrent)		☐ Psoriasis	
☐ CPAP/CIPAP (Circle): Yes No		☐ Pulmonary Embolus (Blood Clot in Lungs)	
☐ Crohn's Disease		☐ Recent Weight Gain	
☐ Degenerative Arthritis - Site: _____		☐ Recent Weight Loss	
☐ Depression		☐ Rectal Bleeding	
☐ Diabetes		☐ Restless Leg Syndrome	
☐ Diarrhea		☐ Rheumatic Fever	
☐ Diverticulitis or Diverticulosis		☐ Schizophrenia	
☐ Dizziness, Vertigo or Lightheadedness		☐ Seborrheic Dermatitis	
☐ Eczema or Chronic Dermatitis		☐ Shortness of Breath (at rest or with exertion)	
☐ Emphysema or COPD		☐ Sinusitis (Chronic)	
☐ Epilepsy/Seizures/Convulsions		☐ Sleep Apnea	
☐ Fibromyalgia		☐ Stroke/CVA/TIA	
☐ Frequent Bladder/Kidney Infections		☐ Rheumatoid Arthritis	
☐ Frequent Headaches/Migraines		☐ Thrombosis (DVT)	
☐ Frequent Nosebleeds		☐ Tinnitus (Ringing in Ears)	
☐ Gallbladder Disease (still have gallbladder)		☐ Tremor/Parkinson's Disease/Essential Tremor	
☐ Glaucoma		☐ Ulcerative Colitis	
☐ Gout		☐ Urinary Incontinence	
☐ Heart Arrhythmia		☐ Other: _____	

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Past Personal Surgical History

Procedure:	Date:	Procedure:	Date:
☐ Adenoidectomy		☐ Gastric Bypass/Lap Band	
☐ Appendectomy		☐ Gastroscopy/Esophagoscopy	
☐ Back Surgery		☐ Hemorrhoidectomy	
☐ Bladder Suspension		☐ Hernia Repair	
☐ Breast Lumpectomy		☐ Hip Fracture Repair	
☐ Bunion Surgery		☐ Hip Replacement	
☐ Carotid Endarterectomy		☐ Hysterectomy	
☐ Carpal Tunnel		☐ Kidney/Ureteral Stone Removal	
☐ Cataract Surgery		☐ Knee Arthroscopy	
☐ Cervical LEEP/Conization		☐ Knee Replacement	
☐ Cesarean Delivery		☐ Laparoscopy	
☐ Colon Resection		☐ Mastectomy	
☐ Colonoscopy		☐ Pacemaker	
☐ Coronary Angiography		☐ Prostate Removal (Cancer)	
☐ Coronary Artery Bypass		☐ Sinus Surgery	
☐ Coronary Balloon Stent Procedure		☐ Skin Cancer	
☐ Cystoscopy		☐ Thyroid Surgery	
☐ D & C		☐ Tonsillectomy	
☐ Ear Ventilation Tubes		☐ Tubal Ligation	
☐ Endometrial Ablation		☐ TURP (Prostate Resection)	
☐ Gallbladder		☐ Vasectomy	
☐ Ganglion Cyst		☐ Other: _____	

Family History

Procedure:	Age:	Relative:	Procedure:	Age:	Relative:
☐ Adopted/No Known Family History	____	_____	☐ High Blood Pressure	____	_____
☐ Alcoholism	____	_____	☐ High Cholesterol Levels	____	_____
☐ Allergic Disorder	____	_____	☐ Lung Cancer	____	_____
☐ Alzheimer's Disease	____	_____	☐ Migraine Headaches	____	_____
☐ Asthma	____	_____	☐ Osteoporosis	____	_____
☐ Blood Clots/Clotting Tendency	____	_____	☐ Prostate Cancer	____	_____
☐ Breast Cancer	____	_____	☐ Rheumatoid Arthritis	____	_____
☐ Colon Cancer	____	_____	☐ Sudden Death at Early Age	____	_____
☐ Colon Polyps	____	_____	☐ Thyroid Cancer	____	_____
☐ Coronary Artery Disease	____	_____	☐ Other Thyroid Disease	____	_____
☐ Stroke/CVA	____	_____	☐ Valvular Heart Disease	____	_____
☐ Depression/Bipolar Disorder	____	_____	☐ Other: _____	____	_____
☐ Diabetes	____	_____	☐ Other: _____	____	_____
☐ Epilepsy/Seizure Disorder	____	_____			

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Health History Form – Social History

Tobacco Use: _____ packs/day Never Used Tobacco: _____
Alcohol Use: _____ drinks/day _____ drinks/week Do Not Drink Alcohol: _____
Education: Less than high school High school/GED College Degree Other: _____
Current Occupation: _____
Do you exercise regularly? Yes No Describe: _____

Adult Immunization History

	Year:
Last Tetanus Dose	_____
Pneumonia Vaccine	_____
Shingles Vaccine	_____
Hepatitis B Series	_____
Mammogram	_____
Male Physical Exam	_____

Health Maintenance

	Month/Year:
Bone Density	_____
Colonoscopy	_____
PAP/Pelvic Exam	_____
Lead Level	_____
Cholesterol Testing	_____
PSA (Prostate Test)	_____

Medication Allergies (list)

Medication Allergies:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current Medications – Please List

Medication:	Dose:	Reason for Taking:	Prescribing Doctor:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Menstrual and Reproductive History (Females Only)

Age Onset of Periods: _____ years old
Length of Periods: _____ days
Number of Tempons: _____ per day
Last Menstrual Date: _____/_____/_____
Are you Menopausal? Yes No
Current Birth Control Method _____
Breakthrough Bleeding? Yes No
Have you used hormone therapy? Yes No

Cycle Interval: every _____ days
Flow: Light Moderate Heavy
Number of Pads: _____ per day
Are you certain? Yes No
Periods irregular? Yes No
Heavy Periods/Clots? Yes No
Age at Menopause: _____ years

Pregnancy History

of pregnancies _____
Full term _____
Premature _____
Abortions _____

Miscarriages _____
Tubal Pregnancies _____
Multiple Births _____
Number Living Children _____