HEALTH PARTNERS FREE CLINIC

Patient Name: _____ Date of Birth: _____ ☐ M ☐ F

Please check the health problems you and your family members have had in the past and, if possible, list the date.

	Self	Family		Self	Family
☐ Heart Disease			☐ Circulatory Problems		
☐ High Blood Pressure			☐ Physical Disability		
☐ Stroke			☐ Chronic Pain		
☐ Lung Disease/Breathing Problems			☐ Skin Condition		
☐ Cancer			☐ Mental Health Problem		
☐ Kidney/Urinary Problems			☐ Hormonal/Thyroid Disorder		
☐ GI/Liver Problems			☐ Seizure Disorder		
☐ Diabetes			☐ Other		

HOSPITALIZATION FOR OPERATION or ILLNESS? Please list year, if possible

_____

_____

_____

Please list ALL medications you are now taking, or should be taking, including over-the-counter vitamins and supplements and the dose.
[If you are currently unable to obtain the medication please list the name of the medication and how long ago you stopped or ran out of it.]

_____

_____

_____

_____

_____

Please turn this paper over and complete the other side.

HEALTH PARTNERS FREE CLINIC

Tell us any drugs you **CAN NOT** take… and the problem you had: (rash, stomach upset, etc.)

_____

_____

_____

_____

Have you ever smoked cigarettes? ☐ Yes ☐ No

If yes: How many packs per day? _____

How long have you smoked? _____

Do you smoke cigarettes now: ☐ Yes ☐ No (Quit Date) _____

If you are still smoking, would you like to discuss ways to help you quit? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

If yes: Daily?_____ Occasionally? _____ Too much? _____

How much do you average? _____ during a (day) (week) (month)

Type of drink (Beer, wine, whiskey, etc): _____

Use of Caffeine: ☐ Yes ☐ No

# of caffeine-containing drinks per day: _____

(Includes coffee, tea, colas, Mountain Dew, "energy drinks", etc.)

Use of other drugs: ☐ Marijuana ☐ Cocaine/Crack ☐ Heroin ☐ Other (list)

_____

Exercise:

Types of exercise: _____

Times per week: _____

When did you last see a doctor? _____ What doctor did you see? _____

Do you have any communication needs? ☐ Hearing ☐ Vision ☐ Other

_____

ARE THERE OTHER THINGS YOU WOULD LIKE US TO KNOW ABOUT YOU?

_____

_____

_____

_____

_____

THANK YOU FOR HELPING US TO PROVIDE YOUR CARE!