HEALTH PARTNERS FREE CLINIC

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

Please check the illnesses you have had in the past and, if possible, list the date	
☐ Heart Disease	☐ Circulatory Problems
☐ High Blood Pressure	☐ Physical Disability
☐ Stroke	☐ Chronic Pain
☐ Lung Disease or Breathing Problems	☐ Skin Condition
☐ Cancer	☐ Mental Health Problem
☐ Kidney/Urinary Problems	☐ Hormonal/Thyroid Disorder
☐ GI/Liver Problems	☐ Seizure Disorder
☐ Diabetes	☐ Other
☐ Other	☐ Other

When is the last time you saw a doctor? _____

What doctor did you see? _____

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

_____

_____

_____

_____

Please turn this paper over and complete the other side.

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	Medication name & dose	# and Frequency	Who Ordered	When was it ordered?	Are you taking this drug now?
	Ex: Metformin 500 mg	*1 daily*	*Dr. Hess*	*2005*	*Yes*
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

HOSPITALIZATION FOR OPERATION or ILLNESS? Please list year

_____

_____

_____

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 yes, would you like to discuss ways to help you quit? ☐ Yes ☐ No

Do you drink alcohol?

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: _____ # Drinks per day: _____

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

Exercise:

Type of exercise: _____

Times per week: _____