Community Health Center CHC

MEDICAL UPDATE

Name *(Last, First, M.I.):*	Date of Birth:	Phone:

MEDICATIONS

Please list any medications that you are currently taking. *Place a checkmark next to any that needs refills.*

☐	☐
☐	☐
☐	☐

Please list any allergies to medications or any other allergies:

Please check here if you do not have any medication allergies ☐ Please check here if you are not on any medications ☐

RECENT HISTORY

Name of Physician:	Phone:

Question		
Have you been seen in the ER in the last 10 days?	☐ Yes	☐ No
Have you been an inpatient at a hospital, rehab, detox or nursing facility in the last 21 days?	☐ Yes	☐ No
Do you have any URGENT medical needs that require you to be seen immediately?	☐ Yes	☐ No
Please explain briefly:		
Who is your health care proxy? (Please provide us with a copy of the document):		
Do you have an advance directive document? (Please provide us with a copy)	☐ Yes	☐ No
Have you seen a specialist recently? (i.e. Neurologist, Orthopedist, Cardiologist, Behavioral Health, etc.)	☐ Yes	☐ No
Do you have thoughts of hurting yourself or others?	☐ Yes	☐ No
Would you like to see a counselor?	☐ Yes	☐ No
For pediatric patients: is the patient in need of immunizations or a time-sensitive physical?	☐ Yes	☐ No
Do you need an antibiotic prior to dental treatment?	☐ Yes	☐ No
Have you ever had any complications following dental treatment?	☐ Yes	☐ No
If yes, please explain:		

Please check any of the following that you need assistance with:

☐ Reading/Writing	☐ Housing	☐ Health Insurance	☐ Language/Interpreter	☐ Transportation

HEALTH ISSUES

☐ AIDS/HIV	☐ Excessive Bleeding	☐ Rheumatic Fever	☐ Pregnancy, Due Date:
☐ Anxiety	☐ Fainting	☐ Radiation Treatment	☐ Rheumatic Fever
☐ Ability to sleep	☐ Growths	☐ Liver Disease	☐ Sexually Transmitted Infection
☐ Arthritis	☐ Hay Fever	☐ Pacemaker	☐ Sinus Problems
☐ Asthma/Emphysema	☐ Heart Disease/ Heart Attack	☐ Ulcers	☐ Stroke
☐ Artificial Joints	☐ Heart Murmur	☐ Glaucoma	☐ Thyroid disease
☐ Blood disease	☐ Hepatitis	☐ Throat	☐ Tuberculosis
☐ Cancer	☐ High Blood Pressure	☐ Rheumatism	☐ Tumors
☐ Depression	☐ Jaundice	☐ Lungs	☐ Vision problems
☐ Diabetes	☐ Kidney Disease	☐ Stomach Problems	☐ Other
☐ Dizziness	☐ Respiratory Problems	☐ Head injuries	
☐ Epilepsy	☐ Alcohol / Drug Dependency (past or present)	☐ Mental Disorders	

Signature:______________________________ **Date:**____________________