Manohar Alloju's Health Center

Clinical history form

First name: _____ Last name: _____ M F
DOB: _____ Age: _____ Race: _____
SSN: _____
Address: _____
Email: _____
Home phone: _____ Cell: _____
Emergency Contact: _____ Relation: _____ Number: _____

Current Medications (may provide own list if preferred)

Name of medication	Strength	Dosing instructions

Allergies (list all allergies)

Past medical history (check all that apply)

- o Alcoholism
- o Diabetes
- o High blood pressure
- o Allergies
- o Bronchitis/COPD
- o High cholesterol
- o Headaches
- o Other: _____

__ Anemia
__ Epilepsy/Seizure disorder
__ Kidney disease
__ Arthritis
__ Glaucoma/Cataracts
__ Liver disease
__ Asthma

__ Osteoarthritis
__ Bleeding disorders
__ Hearing loss
__ Stroke
__ Cancer
__ Heart disease
__ Thyroid disease

Hospitalizations/Surgeries:

Family history (please specify which family member)

__ Asthma __ Heart disease __Diabetes
__ Dementia __ High blood pressure __ Thyroid disease
__ Depression __ High cholesterol __ Stroke
__ Cancer (what kind): _____
__ Other: _____

	Living/Deceased (indicate which one)
Father	
Mother	
Brother (s)	
Sister (s)	

Social History:

Marital status (check the one that applies)

__Single __Married __Widowed __Divorced __Life partner

Children (circle one): Yes or No

How many: ____ Boys ____ Girls

Occupation: _____

Are you sexually active (circle one): Yes or No

Tobacco use:

Are you a current smoker: Yes or No

How many packs a day: _____ For how long: _____

Former smoker: _____ Never smoked: _____

Do you drink alcohol? (Circle one) Yes or No

Do you drink caffeine beverages? (Circle one) Yes or No How many cups per day? _____

Exercise (circle one): Yes or No What type? _____

Immunizations:

Last Flu vaccine: _____ Last Pneumonia vaccine: _____

Last Shingles Vaccine: _____ Last Mammogram (if apply): _____