CCH Medical Clinic
929 Stacy Burk Drive
Flora Il. 62839

Louisville Medical Clinic
935 Bryant Street
Louisville, Il. 62858

Clay City Medical Clinic
800 Kelly Drive SW
Clay City IL 62834

Health History Form

Patient's Name: _____Date of Birth: _____

Section 1: Allergies

1. Are you allergic to any medication? □ No □ Yes
2. If yes, what are you allergic to and what type of reaction did you have?_____

Section 2: Medications - *Bring all medications to all office visits*

1. What is your preferred pharmacy? _____
2. Are you currently taking any medications? □ No □ Yes
3. If yes, please list below and/or show your medication bottles to the nurse.

Medication or Herbal Supplement	Strength	Form (capsule, tablet)	Directions

Section 3: Reason for visit

□ Routine Checkup □ Illness/Complaint Briefly describe: _____
□ Injury/Accident – Date/Describe: _____

Section 4: Pregnancy/Birth History – *Skip to section 5 if does not apply*

1. Antenatal
   a. Gravida (number of pregnancies): ___
   b. Para (number of deliveries): ___
   c. Abortion: ___
   d. Living: ___

e. Did the mother of the child take any of the following during the pregnancy?

Medications □ No □ Yes, _____

Drugs □ No □ Yes

Alcohol □ No □ Yes

Tobacco □ No □ Yes

2. Labor and delivery
   a. Gestational age at birth ___ weeks ___ days
   b. Birth weight ___lbs. ___ oz.
   c. Length ___inches ___cm
3. Hospital Course
   a. Hepatitis B vaccine given □ No □ Yes
   b. Hearing test □ Pass □ Fail
   c. Jaundice □ No □ Yes
4. Discharge
   a. Feeding History □ Breast □ Bottle □ Both
   b. Formula type _____
   c. Discharge date _____
   d. Discharge weight ___ lbs. ___ oz.

Section 5: Past medical History – *Please mark all that apply*

□ ADD	□ Chicken Pox	□ Gallbladder Disease	□ Myocardial Infarction (Heart Attack)
□ ADHD	□ Chronic Ear Infections	□ GERD	□ Osteoporsis
□ Allergies – Food, insect sting, pet, or seasonal	□ Concussion	□ Headaches, migraine	□ Pneumonia
□ Anemia	□ Congenital heart disease	□ Hearing Problems	□ Renal Disorder
□ Anxiety	□ COPD	□ Heart disease	□ Seizure Disorder
□ Arthritis	□ Coronary Artery Disease	□ Heart murmur	□ Seizures, febrile
□ Asthma	□ Depression	□ Heart valve disorder	□ Stroke
□ Atrial Fibrillation	□ Diabetes – Type 1, Type 2, or Gestational	□ Hepatitis/Liver Disease	□ Thyroid Disease
□ Benign Prostatic hypertrophy (enlarged prostate)	□ Eczema	□ Hypertension	□ Other
□ Blood clots	□ Elevated Lipids	□ Irritable Bowel Disease	
□ Cancer	□ Fracture	□ Menstrual Problems	

Section 6: Past Surgical History – *Please mark all that apply*

	Date		Date
□ Adenoidectomy		□ Ear tubes (Myringotomy and Tympanostomy Tubes)	
□ Angioplasty		□ Gastric Bypass	
□ Appendectomy		□ Hernia Repair	
□ Arthroscopy		□ Hernia Repair, inguinal	
□ Back Surgery		□ Hernia Repair, Umbilical	
□ Blood Transfusion		□ Hip replacement Side _____	
□ CABG (Coronary Artery Bypass Surgery)		□ Knee replacement Side _____	
□ Cardiac Pacemaker		□ LASIK (eye surgery)	
□ Carpal Tunnel Release		□ Lymph node biopsy/excision	
□ Cataract Extraction		□ ORIF (Surgical Repair of bone)	
□ Cholecystectomy (gallbladder)		□ Thyroidectomy	
□ Circumcision		□ Tonsillectomy	
□ Colectomy (colon resection)		□ Other	
□ Dental Surgery			

Section 7: Family History

	Relationship		Relationship
□ ADD/ADHD		□ Elevated Lipids	
□ Alcoholism		□ Genetic Disease	
□ Allergies		□ Hearing deficiency	
□ Alzheimer's Disease		□ Hypertension	
□ Arthritis		□ Irritable Bowel Disease	
□ Asthma		□ Migraines	
□ Biopsy Type_____		□ Obesity	
□ Birth Defects		□ Osteoporosis	
□ Cancer Type		□ Peripheral Vascular Disease	
□ Cardiovascular Disease		□ Renal Disease	
□ Coronary Artery Disease		□ Seizure Disorder	
□ Depression		□ Stroke	
□ Diabetes		□ Thyroid Disorder	
□ Eczema		□ Other	

8: Social History Section

1. Tobacco – Do you use tobacco? □ No □ Yes □ Formerly
2. Alcohol – Do you drink Alcohol? □ No □ Yes □ Formerly
3. Drug Use – Do you use recreational drugs? □ No □ Yes □ Formerly
4. Status
   a. What is your highest level of education? _____
   b. What is your current marital status? _____
5. Relationship
   a. If the patient is a child, who does the child primary live with? _____
   b. If the patient is a child, does the child have a secondary residence? _____
   c. What is the parent's marital status? _____
   d. Are there smokers at home? _____ If yes, are the smokers inside, outside, or both? _____
6. Education
   a. What is the child's school name: _____
   b. What grade is the child currently in: _____

Section 9: Diagnostic History

1. If female, have you had a Pap? □ yes □ no If yes, when? _____
2. Have you had a mammogram? □ yes □ no If yes, when? _____
3. Have you had a colonoscopy? □ yes □ no If yes, when? _____
4. Have you had an Esophagogastroduodenoscopy (EGD)? □ yes □ no If yes, when?_____

Section 10: Immunizations

1. If you are under the age of 18 and have had immunizations done in a state, please give a copy of the record to the clinic.
2. If you are over the age of 18
   a. When was your last pneumonia injection? _____
   b. When was your last Influenza injection? _____
   c. When was your last HPV vaccine? _____
3. If you are 60 or older, have you had the Herpes Zoster/Shingles vaccine? _____

Section 11: Advanced Directives

1. Do you have a Living Will? □ Yes □ No
2. Do you have a Medical Power of Attorney? □ Yes □ No If yes, who? _____
3. Do you have a DNI (Do Not Intubate)? □ Yes □ No
4. Do you have a DNR (Do not Resuscitate)? □ Yes □ No

If you marked yes to any of the above, please supply a copy of the document to the front desk.