COMPREHENSIVE HEALTH CLINICS **763-689-2462**
137 2ND AVE. SW, CAMBRIDGE, MN 55008 **FAX: 763-689-1688**

PATIENT & FAMILY HISTORY

Preferred language (spoken & written) □ English □ Spanish □ _____
Race □ White □ Hispanic/Latino □ Asian □ Black/African American □ Native Hawaiian/Pacific Islander
□ Multi-Racial □ American Indian/Alaska Native □ Decline to answer
Ethnicity □ Not Hispanic/Latino □ Hispanic/Latino □ Declined to Specify

What is your occupation? _____
What is your employment status? □ Full time □ Part time □ Working □ Sick leave □ Unemployed □ Retired
□ Temp disability □ Perm Disability

Do you use tobacco? □ Never □ Former □ Current □ Some days □ Everyday
Do you consume alcohol? □ Yes □ No Frequency _____
Have you ever been treated for substance abuse? □ Yes □ No
Severe accidents or trauma dates _____

Are you pregnant? □ Yes □ No Due date _____

ALLERGIES □ Yes □ None (medications, latex, iodine, etc.)

MEDICATIONS □ Yes □ None

DIAGNOSIS (or health conditions you have)

_____

_____

PAST SURGICAL HISTORY (list all surgeries and age when you had them)

_____

_____

✓ **ALL THAT APPLY TO YOU NOW AND IN THE PAST:**

□ Arthritis/Gout	□ Depression/Anxiety	□ Pregnancy	□ High Cholesterol	□ Headaches
□ Eye Pain/Strian	□Dizziness	□ Seizures	□ Ringing in Ears	□ Blurred Vision
□ Jaw Pain	□ Hepatitis C	□ Neck Pain/Spasms	□ Chronic Fatigue	□ Heart Disease/Attack
□ Gall Stones	□ Swallowing Difficulty	□ Thyroid Problems	□ Chest pain/SOB	□ Cancer
□ Shortness of Breath	□ Irregular heartbeat	□ HIV/AIDS	□ Asthma/Bronchitis	□ Mid/Low Back Pain
□ Shoulder/Elbow Pain	□ Wrist/Hand Pain	□ Neuropathy	□ Hip/Knee/Leg Pain	□ Foot/Ankle Pain
□ Stomach/Ulcer Pain	□ Diabetes	□ Groin/Rectal Pain	□ Female Disorders	□Urinary Problems
□ Skin Problems	□ Broken Bones	□ Digestive Problems	□ Emphysema/COPD	□ Irregular Bowels

FAMILY HISTORY

Father □ Living □ Deceased Cause of Death _____
Mother □ Living □ Deceased Cause of Death _____
Brother □ Living □ Deceased Cause of Death _____
Sister □ Living □ Deceased Cause of Death _____
_____ □ Living □ Deceased Cause of Death _____

_____
Print Name of Patient

✗ _____ _____
Signature (if minor, parent must sign) Date Provider Signature