Banyan Community Health Center, Inc.

Patient History Form

Name: Date: / / DOB: / /

Last First Middle

Name of your Doctor | When did you last see your Doctor

LEARNING NEEDS ASSESSMENT

What languages do you speak? English □ Spanish □ Creole □ Other □

What languages do you read? English □ Spanish □ Creole □ Other □

What is your highest level of education?

Grade – 6 □ 7 – 12 □ College □ None □

How do you prefer to learn? One-on-one education □ Group education □ Handouts □ Pictures □ Videos □ Audio tapes □

Do you have any special educational needs we should be aware in the following areas?

Hearing □ Sight □ Speech □ Spiritual □ Cultural beliefs □

Yes □ No □ If yes, please explain

At this time, do you have any limitation or emotional barriers that may affect your ability to learn?

Job □ Separation □ Death □ Move □ Other □

PAST MEDICAL HISTORY AND SURGICAL HISTORY AND HABITS

Are you taking any prescribed, over-the-counter or herbal medicines? ☐ Yes ☐ No

If yes, list all medications you are currently taking:

Are you allergic to any medications, food, etc.? Yes □ No □

Do you have or you have had any of the following?

	Yes	No		Yes	No		Yes	
High blood pressure	☐	☐	Street drug use now	☐	☐	Tuberculosis	☐	☐
Heart disease	☐	☐	Street drug use in the past	☐	☐	Blood transfusion	☐	☐
Diabetes	☐	☐	Positive TB skin test	☐	☐	HIV disease	☐	☐
High cholesterol	☐	☐	Cancer	☐	☐	Epilepsy	☐	☐
All exercise program	☐	☐	Kidney disease	☐	☐	Osteoporosis	☐	☐
Tobacco use now	☐	☐	Hepatitis	☐	☐	Mental health problems	☐	☐
Tobacco use in the past	☐	☐	Asthma	☐	☐			
						Other diseases	☐	☐

Have you ever been a victim of abuse / neglect? ○ Yes ○ No

Have you ever been in the hospital? ○ Yes ○ No

Have you ever had any falls, trauma, or other injury? ○ Yes ○ No

Have you ever had surgery? ○ Yes ○ No

If yes, please indicate Hospital / Surgery below.

Where (Doctor/Hospital)	Year	Reason

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PATIENT HISTORY FORM

During the last month, have you often been bothered by?	Yes	No
Little interest or pleasure doing things	☐	☐
Feeling down, depressed or hopeless	☐	☐
Feeling worried, tense or anxious most of the time	☐	☐
Feeling irritable and having trouble sleeping	☐	☐

	Yes	No
Have you lost significant weight recently?	☐	☐
Do your daily activities require that you stay In the sun often?	☐	☐
Have you ever been exposed to asbestos, Radiation, chemicals, or fumes?	☐	☐

What is your usual diet?

Regular ☐ Atkins ☐ Vegetarian ☐ Low Salt ☐ Low cholesterol ☐

FUNCTIONAL ASSESSMENT

Are you able to do these for yourself?

	Yes	No		Yes	No
Bathing	☐	☐	Shopping	☐	☐
Dressing	☐	☐	Feeding	☐	☐

SEXUAL HISTORY

Are you sexually active? ○ Yes ○ No

Current contraceptive method? ○ Yes ○ No

Number of partners in past 5 years: _____

Have you had sex:

With a man who has sex with men ○ Yes ○ No

With a person with HIV/AIDS ○ Yes ○ No

With an injecting drug user ○ Yes ○ No

For drugs or money ○ Yes ○ No

FAMILY HISTORY

(mark with an X)	Living	Deceased	Cause
Mother	○	○	
Father	○	○	

Siblings : Number living _____ Number Deceased _____ Cause

Has anyone in YOUR FAMILY had any of the following (parents, grandparents, brothers, sisters)?

	Yes	No		Yes	No
High blood pressure	☐	☐	Asthma	☐	☐
Heart disease	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	HIV disease	☐	☐
High cholesterol	☐	☐	Epilepsy	☐	☐
Cancer	☐	☐	Mental health problems	☐	☐
Kidney disease	☐	☐	Osteoporosis	☐	☐
Hepatitis	☐	☐	Other diseases	☐	☐

SOCIAL HISTORY

Are you currently employed ○ Yes ○ No

Who do you live with? _____

SAFETY

I wear my seat belt ○ Yes ○ No

I have a smoke detector ○ Yes ○ No

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FOR WOMEN ONLY

	Yes	No
Have you had a recent Pap Smear?	☐	☐
Mammogram?	☐	☐
Date of last period		
Any menstrual problems or recent changes?	☐	☐

History of Pregnancies

How many times have you been pregnant? _____

How many abortions have you had? _____

How many ectopic pregnancies have you had? _____

How many full term pregnancies have you had? _____

How many of your children are living? _____

Patient History Form

Print Name: _____

Date of Birth: _____ / _____ / _____

To ensure that we provide you with safe, quality health care, is there any other information we should be aware of?

Yes ☐ No ☐

SIGNATURE OF PATIENT _____ **Date** _____

NURSE/MA _____ **DOCTOR** _____