Feliz Care Centers

Health History English

Name of patient:_____ Date of Birth_____ Sex M / F Race_____ Allergies_____
Please list all people in household-

Spouse_____DOB_____Occupation_____Education_____

Other_____DOB_____Occupation_____Education_____

Other_____DOB_____Occupation_____Education_____

Other_____DOB_____Occupation_____Education_____

Other_____DOB_____Occupation_____Education_____

Past Medical History- Are you in -- GOOD // FAIR // POOR Health? Are you Taking any Medication Y // N. Please list hospitalizations, operations, serious illnesses and or accidents with dates.

_____
_____
_____

Have you had any problems with one or more of the following? Please circle Y or N. (If Yes please provide more detail below.)

(Physical)

Eyes/ Vision	Y/N	Feet	Y/N	Digestion/Nutrition	Y/N	Ears/Hearing	Y/N	Urine/Kidney	Y/N
Joints	Y/N	Skin	Y/N	Lungs	Y/N	Teeth	Y/N	Heart	Y/N
Seizures	Y/N			Exposed to Cigarette smoke	Y/N			Take any medications	Y/N

Family History

Has anyone in the immediate family died suddenly? Y/N If yes, list age and cause_____

Have any of your immediate blood relatives had any of the following diseases? If Yes list family member.

Heart Disease Y/N _____Tuberculosis Y/N _____High Blood Pressure Y/N _____
Kidney Disease Y/N _____Allergies/Asthma Y/N _____Cancer Y/N _____
Diabetes Y/N _____Mental Health Issues Y/N _____Sickle Cell Y/N _____
Siezures Y/N _____

Do you : Use tobacco Y/N Drink Beer or alcoholic beverages Y/N Use any Kind of Drug Y/N
Are you sexually active Y/N If Yes Do you use birth control Y/N Have you ever been pregnant or fathered a child Y/N For females—How old were you when you had your first period?_____

Do you have any concerns about the following---Safety issues Y/N Substance Use Y/N STD's Y/N Family Planning Y/N
Other please explain_____