Partners in Health Community Access Program

Health History Form

Directions
Shade circles like this: ●
Do not shade like this: ⊘ ⊘

Please complete using blue or black ink.

Today's Date 02 / 07 / 2002 (m m / d d / y y y y)

Primary Care Facility: 9

Social Security Number 458 / 79 / 2541

Enrollment Status ● NEW ○ Re-enrolled ○ UPDATED ○ Re-INSTATEMENT Request

First Name: JANE **Last Name:** DOE **M. I.** P

Date of Birth: 11 / 15 / 1957 **Gender:** ○ Male ● Female

Employed? ● Yes ○ No

Employer : SPECIAL TOUC

Occupation : NURSE AID

Do you have a diagnosis of? (Check all that apply)

● Diabetes ● Asthma ● Hypertension ● Depression ○ None of these

Have you had any of the following tests? (most recent date)

Colonoscopy/Sigmoidoscopy :	○ Yes	○ No	Date:	/ (m m / y y y y)
Blood in stool :	○ Yes	○ No		
(Females Only)				
Mammogram :	○ Yes	○ No	Date:	/ (m m / y y y y)
PAP :	○ Yes	○ No	Date:	/ (m m / y y y y)
For Future Use:	○ Yes	○ No	Date:	/ (m m / y y y y)

Have you had any of the following vaccinations?

Pneumonia Shot :	○ Yes	○ No	Date:	/ (m m / y y y y)
Flu Shot :	● Yes	○ No	Date:	12 / 2001 (m m / y y y y)

Do you use tobacco? ○ No ○ Smoke ○ Smokeless

Alcohol use? ○ No Average number in one week :

Within the last six months :

1. Have you been to the ER? ● Yes ○ No For what reason? Acute Asthma

2. Have you been hospitalized? ○ Yes ○ No For what reason?

Eligible for a hospital discount? ● Yes ○ No

Household size? 04

Total monthly income? 2003

29044