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 ☐☐ / ☐☐ / 20☐☐ (m m / d d / y y y y)

Primary Care Facility: ☐

Social Security Number ☐☐☐ / ☐☐ / ☐☐☐☐

Enrollment Status
○ New ○ Update ○ Re-Enrollment ○ Re-Instated

Date: ☐☐ / ☐☐ / 20☐☐ (m m / d d / y y y y)

Enrollment Type: ☐☐☐

First Name: ☐☐☐☐☐☐☐☐☐☐☐☐

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

M. I. ☐

Date of Birth: ☐☐ / ☐☐ / 19☐☐

Gender: ○ Male ○ Female

Employed?
○ Yes ○ No

Employer : ☐☐☐☐☐☐☐☐☐☐☐☐

Occupation : ☐☐☐☐☐☐☐☐☐☐☐☐

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)

Have you had any of the following vaccinations?

Pneumonia Shot :	○ Yes	○ No	Date:	☐☐ / ☐☐☐☐ (m m / y y y y)
Flu Shot :	○ Yes	○ No	Date:	☐☐ / ☐☐☐☐ (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?

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

Eligible for a hospital discount?
○ Yes ○ No

Household size? ☐☐

Total monthly income? ☐☐☐☐

32208