

PERSONAL HISTORY

INFORMATION

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Marital Status: _____ Sex: _____

Address: _____

Phone #: _____ Health Care #: _____

Emergency Contact Person: Name: _____

Relationship: _____

Phone: _____

CHIEF COMPLAINT: Please describe the reason for your visit today.

MEDICATIONS: Please list the names.

ALLERGIES: _____ Yes _____ No

If so, please list: _____

SURGICAL HISTORY: Please list any prior surgeries (include year).

MEDICAL HISTORY: Have you ever had any of the following? When?

Asthma	☐ Yes	☐ No	Strokes	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Thyroid Disorder	☐ Yes	☐ No
Asthma	☐ Yes	☐ No			
High Blood Pressure	☐ Yes	☐ No			
Cancer	☐ Yes	☐ No	If yes, what type?		
Other (please list):					

CLB4 only:

FAMILY HISTORY:

If living:			If dead:
RELATION	AGE	HEALTH CONDITIONS	AGE AT DEATH
Mother			
Father			
Siblings			

Signature: _____ Date: _____

Modified from MiraCost College Noncredit ESL Program, El Civics Assessment, Health 28.1 (Advanced)