



Courage Center Primary Care Clinic
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Primary Care Clinic Health Information Form

Identification		Emergency Contacts	
Name (Last) (First) (Middle)		In Case of Emergency, Notify: Primary Contact Name (last) (First)	
Date of Birth	Sex: Male Female		
Height	Weight	Relationship	
Race		Phone	
Primary Language			
Person or Family Member Helping Complete Form			
Healthcare Providers			
Healthcare Provider Specialty	Primary Care Physician Yes No	Phone	
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City		State	Zip Code

Primary Care Clinic Health Information Form

Name: _____ DOB: _____

Healthcare Provider Specialty	Specialty:	Phone	
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City		State	Zip Code

Healthcare Provider Specialty	Specialty	Phone	
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City		State	Zip Code

Healthcare Provider Specialty	Specialty	Phone	
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City		State	Zip Code

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Social History

Lives with:			
Marital Status:	Married	Divorced	Single Widowed Significant Other
Children:			
Housing:	House	Apt	Trailer Condo Group Home Nursing Facility

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Name: _____ DOB: _____

Location:		
Accessibility: Are there obstacles in your home that make it difficult to get around?		
Occupation: Are you currently working? Not-employed Full-time Part-time On work restrictions On disability		
Hobbies:		
Lifestyle		
How much alcohol do you use per week?	Drink(s) Per Week	Number of Years
Do you smoke? If so, how much?	Pack(s) Per Day	Number of Years
Do you currently exercise?	What type(s) of Exercise?	How many days Per week?
Have you ever used any illicit drugs in the past or present?		
Are you on a special diet: Type:		
What is your current weight:		
Have there been any recent weight loss or gain ? If so, how many lbs?		
Health Maintenance		
When was your last annual physical? Where?		
Have you ever had your bone density tested? If so, where?		
For females, when was your last mammogram?		
When was your last Tetanus shot?		
Have you ever had a Pneumonia Vaccine?		
Have you ever had a Colonoscopy?		
When was your last Eye exam?		
When was your last Dental exam?		
When was your last Cholesterol screening?		

Primary Care Clinic Health Information Form

Name: _____ DOB: _____

Family Member History					
	Mother	Father	Sibling(s)	Grandparent(Children
Enter ages of relatives					
If deceased, indicate age and cause of death					
Check all items that apply for their present state of health or any illnesses they have had					
Alcoholism					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Glaucoma					
Heart Condition					
High Blood Cholesterol					
High Blood Pressure					
Kidney Disease					
Seizures					
Stroke					
Thyroid Disorders					
Activities of Daily Living:					
Mobility: W/C powered <input checked="" type="checkbox"/> W/C manual Scooter FWW SEC					
Transfers: With assistance of _____ Independent					
Stairs: Unable With Assistance					
PCA: Yes Hours per day: _____					
Money Management: Independent With assistance Someone else manages					
Speech Language: Dysarthria <input checked="" type="checkbox"/> Swallowing problems <input checked="" type="checkbox"/> Speech therapy in the past					

Primary Care Clinic Health Information Form

Name: _____ DOB: _____

Review of Systems

Circle the condition you have now. Put an X by those you have had in the past.

AIDS / HIV

Hepatitis

Anemia

Hypertension

Arthritis

Incontinence of Bladder

Asthma

Incontinence of Bowel

Blood Clots / Transfusion

Kidney disease

Bronchitis / Cough

Low Blood Pressure

Cancer

Nausea / Vomiting

Diabetes

Neurogenic Bladder

Dizziness / Balance problems

Neurogenic Bowel

Double Vision

Pain in Muscles / Joints

Edema / Swelling

Palpatations

Emphysema / Lung Problems

Paraplegia / Quadriplegia

Epilepsy / Seizures

Rheumatic Fever or Rheumatic Disease

Fainting

Skin Ulcers

Fever / Chills

Shortness of Breath

Frequent or Severe Headaches

Stomach, Liver, or Intestinal Problems

Glasses for Distance or Near

Stroke

Hearing Problems / Ringing in the Ears

Tracheotomy Previously

Heart Disease

Thyroid Problems

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Name: _____ DOB: _____

Mental Health History

Do you see a Psychiatrist:

If so, what is his or her name?

Do you see a Psychologist:

If so, what is his or her name?

Do you have any anxiety?

Do you have any Depression?

Did you or are you having trouble adjusting to your disability?

Have you ever been diagnosed with Bipolar Disorder?

Other:

