Sunshine Community Health Center
HC89 Box 8190 ◆ Talkeetna, Alaska 99676 ◆ Mile 4.4 Talkeetna Spur Road ◆ Telephone: (907) 733-2273 ◆ Fax: (907) 733-1735
Willow Clinic: P.O. Box 1049 ◆ Willow, Alaska 99688 ◆ 24091 Long Lake Road ◆ Telephone: (907) 495-4100 ◆ Fax: (907) 495-4106

Patient Name:_____ Today's Date:_____

Drug Allergies & type of reaction:

Current Medications (Including over-the-counter medications and herbals): □ **No medications**

Name of Medication	Dose	Number of times taken each day

Health History: Do you have or have you ever had problems with the following: (please circle)

Frequent/severe Headaches	High Blood Pressure	Liver Disease	Blood Disorder
Migraines	Heart Murmur	Hepatitis	Blood Transfusion
Fainting spells	Heart valve problem	Frequent or painful urination	Cancer
Seizures	Heart Surgery	Kidney stone/ blood in urine	Exposure to toxins
Stroke	Shortness of breath	Sexually Transmitted Disease	Skin problems
Head injury	Chronic cough	HIV Positive	Self-confidence concerns
Vision problems	Asthma	Immune Problem	Eating disorder
Glaucoma	Emphysema	Swollen or painful joints	Depression
Hearing loss	Tuberculosis	Chronic back pain	Anxiety
Sinus problems	Coughing up blood	Gout	Suicide attempt or plan
Thyroid	Heartburn	Arthritis/Rheumatism/Bursitis	Domestic Violence
Breast problems	Stomach Problem	Osteoporosis	Sexual Abuse
Chest Pain	Hernias	Joint Replacements	OTHER:_____
Palpitation or heart pounding	Gallbladder	Nerve injury	
Heart Attack	Diabetes	Blood clots	
Heart Disease	High Cholesterol	Anemia	

Surgeries: Please start with the most recent

Date	Reason for visit/surgery	Date	Reason for visit/surgery

Family History: Are you adopted ? □YES □NO If NO complete table below:

	Deceased?		Age	Medical Problems/ Cause of death
Mother	Yes	No		
Father	Yes	No		
Siblings	Yes	No		
Children	Yes	No		

Social History:

Marital Status (Circle one): Single Single w/partner Married Separated Divorced Widowed

Who lives at home with you:_____ Do you feel safe in your home? □YES □NO

Occupation:_____ Educational level:_____Hobbies/Interests:_____

Overall, how would you describe your relationship with your partner: 0----------1----------2----------3----------4----------5
no tension some tension a lot of tension

Do you and your partner work out arguments: 0----------1----------2----------3----------4----------5
no difficulty some difficulty great difficulty

Recent Immunizations/Health Screens: Have you had any of the following in the last 5 years? Please **circle** if yes

Tetanus	Pneumonia	Fecal Occult	Cholesterol	Pap (Women only)
Tdap	Hep B series	Flex Sig or	PSA (Men only)	Mammogram (women
Flu Vaccine	Dental exam	Colonoscopy	Vasectomy (Men only)	only)

Do you have a Living Will or Comfort One ? □YES □NO

WOMEN ONLY:

Age you started your period:_____ How long are your cycles?_____ How long do your periods last?_____

Are your periods Irregular? □YES □NO Date of last menstrual cycle_____ Hysterectomy? □YES □NO

Date of Last Pap Smear:_____ Previous Abnormal Pap? □YES □NO

Using Birth Control? Type: □YES Type:_____ □NO Are you pregnant? □YES □NO

Breast Feeding? □YES □NO # Pregnancies:_____ # Children:_____ # Miscarriages:_____

Pregnancy complications? □NO □YES Type:_____