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:

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

Surgeries: Please start with the most recent

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

Family History: Are you adopted? 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:
Who lives at home with you:_______________________________________ Do you feel safe in your home?
Occupation:_________________________ Education level:_____________________ Hobbies/Interests:___________________
Overall, how would you describe your relationship with your partner:
Do you and your partner work out arguments:

Recent Immunizations/Health Screens: Have you had any of the following in the last 5 years?

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

Do you have a Living Will or Comfort One?

WOMEN ONLY:
Age you started your period:______ How long are your cycles?________ How long do your periods last?___________
Are your periods Irregular? Date of last menstrual cycle: ______ Hysterectomy?
Date of Last Pap Smear: _________ Previous Abnormal Pap? Are you pregnant?
Using Birth Control? Type:_________________
Breast Feeding? # Pregnancies:__________ # Children:_____________ # Miscarriages:_______________
Pregnancy complications? Type:____