Siskiyou Community Health Center
Annual Health Review

Today's Date: _____

Name: _____ **Date of Birth:** _____

Please complete the following questions to the best of your ability.

COORDINATION OF CARE

Are you being seen in any specialty offices outside of Siskiyou Community Health Center (Endocrinology, OB/GYN, cardiology, rheumatology, ophthalmology, etc.)? ☐ Yes ☐ No
If yes, where? _____

_____

Who is your dental provider? _____ When was your last exam? _____
What is your preferred pharmacy? _____ Pharmacy Location: _____

HEALTH MAINTENANCE

Do you have any new health problems or concerns today? ☐ Yes ☐ No
If yes, what are your symptoms and how long have you had them? _____
**Please note, if you are not scheduled to see your provider for the above specified issue, you may need to schedule another appointment.

ALLERGIES

☐ **No Allergies**
Please list any of your allergies and your reaction: _____

IMMUNIZATIONS

If you are due for any immunizations would you like to receive them at your appointment? ☐ Yes ☐ No ☐ Unsure
Would you like more information on the vaccines you are due for or may be due for soon? ☐ Yes ☐ No

COLORECTAL CANCER SCREENING

Have you had a colonoscopy within the last 10 years? ☐ Yes ☐ No If yes, approximate date: _____
Provider/location where the procedure was performed: _____
If you are over age 50 and have not had a colonoscopy, would you like to discuss a referral with your provider? ☐ Yes ☐ No

WOMEN'S HEALTH

Date of last Pap _____ Where last Pap/Annual exam was done _____
Have you ever had an abnormal Pap? ☐ Yes ☐ No If yes, when? _____ Date of last mammogram: _____

Do you currently use a birth control method? ☐ Yes ☐ No
If yes, what method? _____ Are you happy with your current method? ☐ Yes ☐ No

Have you had a hysterectomy? ☐ Yes ☐ No Have you had a tubal ligation? ☐ Yes ☐ No
If you have had a hysterectomy or a tubal ligation, when and where? _____

SOCIAL HISTORY

Have you ever used tobacco products (cigarettes, E-Cigs, chew, cigars, etc.)? ☐ Yes, current ☐ Yes, Past ☐ No/Never
If yes or formerly, what type/types? _____
How much and how often? _____ Age/Year Started: _____ Age/Year Quit: _____

Do you drink caffeine? ☐ Yes ☐ No If yes, what type? _____ How much daily? _____

Do you or have you previously used recreational drugs? ☐ Yes ☐ No ☐ Former
If yes or formerly, what type/types? _____
How much and how often? _____ Age/Year Started: _____ Age/Year Quit: _____

PERSONAL AND FAMILY HEALTH HISTORY

Please check whether or not any of these problems apply to you. If any of your relatives have had the diagnosis, please list their relationship to you.

Diagnosis	Self	Relative	Diagnosis	Self	Relative
ADD / ADHD			Elevated cholesterol		
Alcoholism			Genetic Disease		
Allergies			Hearing Deficiency		
Alzheimer's Disease			High Blood Pressure		
Arthritis			Irritable Bowel Disease		
Asthma			Learning Disability		
Blood Disorder			Mental Illness		
Cancer			Migraines		
Cardiovascular Disease			Obesity		
Coronary Artery Disease			Osteoporosis		
Coronary Artery Disease, Premature			Peripheral vascular disease		
Depression			Renal Disease		
Developmental Delay			Seizure Disorder		
Diabetes Type _____			Stroke		
Eczema			Thyroid disorder		

If you have any other health conditions that are not listed in the above table or have had any surgeries, please write them in the table below.

List Medical Conditions and Surgeries	Current? Y/N	Date diagnosed	Provider/Office that Diagnosed

Surgeries	Approximate Date	Provider that Performed

MEDICATIONS

Please include any current medications in the table below (prescription medications, over the counter, supplements and vitamins).

Medication Name	Dose Instructions (Example: 1mg tablet, twice daily)	Prescribing Physician