CCC Medical History Form

Directions: Please answer the following questions to the best of your knowledge.

Your records are considered confidential. Your records will not be released to any party without your written consent.

PATIENT INFORMATION				
Last Name	**First Name**	**Middle**	**Primary Language**	**Social Security No.**
Street Address	**City**	**State** **Zip**	**OK to Send Letter?** ⎕ Yes ⎕ No	**Sex:** ⎕ Male ⎕ Female
Home Phone	**OK to Call?** ⎕ Yes ⎕ No	**Work Phone**	**OK to Call?** ⎕ Yes ⎕ No	If No, How can you be reached?
Birthdate	Marital Status: ⎕ Single without partner ⎕ Single with partner Length of Time: _____ ⎕ Married ⎕ Separated ⎕ Divorced ⎕ Widowed			
Sexual Orientation ⎕ Heterosexual ⎕ Homosexual ⎕ Bisexual				
Children: ⎕ Yes ⎕ No How Many?		**Number of Persons Living in Your Home?**		**Race/ Ethnicity**
Emergency Contact Person		**Phone Number**	**Relationship**	

PRIMARY PHYSICIAN(S)		
Name	Name	Name
Address	Address	Address
Phone:	Phone:	Phone:

Medication Allergies? ⎕ Yes ⎕ No

If yes, what medication(s) _____

Substance or Food Allergies? ⎕ Yes ⎕ No

If yes, what substance(s)_____

FAMILY HISTORY: Please check if your family has a history of:

⎕ Diabetes ⎕ High Blood Pressure ⎕ Heart Attack, Heart Disease ⎕ Blood Clots or Stroke ⎕ Tuberculosis

⎕ Cancer ⎕ Alzheimer's ⎕ Family History Unknown ⎕ Mental Illness ⎕ Epilepsy/Seizure

⎕ Anxiety ⎕ Depression ⎕ Alcoholism ⎕ Drug Abuse

Any other major conditions? _____

If you answered Yes to any of the above, please explain: _____

Are you currently being treated for medical conditions? ⎕ Yes ⎕ No If yes, please list: _____

MEDICATIONS (List more on separate page if necessary)

Current Medications	For what condition?	Dosage	Frequency	Date started	Comments / Problems / Concerns

Past medications / For what condition? (list sedatives, pain medications, sleeping pills, antidepressants, etc.)			

Social/Sexual Risk History		
Yes	No	Do you smoke? If yes, how many cigarettes per day?
Yes	No	Do you use alcohol? If yes, how often, how much?
Yes	No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)
Yes	No	Have you ever had or would you like help now with an alcohol or drug problem?
Yes	No	Would you like to discuss problems related to a rape or emotional/physical/sexual abuse?
Yes	No	Are you now or have you ever been in a relationship where you have been physically hurt or threatened?