Chase City Primary Care Center, Chase City VA
A Service of VCU Community Memorial Hospital

Patient History Record

Name _____ DOB _____

Race _____ Gender _____ Marital Status _____

List any Allergies: _____

_____

_____

Previous Surgery – Hospitalization – Injury:

Date	Description
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

List of other healthcare providers you have seen in the past year:

Date	Name of Dr.	Reason for Visit
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:

	Date of Birth	Age at Death	Cause of Death
Father			
Mother			
Sibling			
Sibling			
Sibling			

History of Diseases:

You	Your Family	Relationship	
_____	_____	_____	Mumps, Measles, Chicken Pox
_____	_____	_____	Rubella, German Measles
_____	_____	_____	Anemia
_____	_____	_____	Sickle Cell
_____	_____	_____	Blood Transfusion (Give Date :_____)
_____	_____	_____	Uncontrolled Bleeding
_____	_____	_____	Cancer (List type :_____)
_____	_____	_____	Diabetes
_____	_____	_____	Thyroid Disease; Goiter
_____	_____	_____	Kidney/Bladder Problems
_____	_____	_____	Alcoholism
_____	_____	_____	Nervous Breakdown; Mental Illness (Circle)
_____	_____	_____	Seizure; Epilepsy
_____	_____	_____	Suicide Attempt
_____	_____	_____	Migraine
_____	_____	_____	Depression
_____	_____	_____	Eye Problems; Glaucoma
_____	_____	_____	Colitis
_____	_____	_____	Ulcer, Stomach, Liver Disease; Hepatitis (Circle)
_____	_____	_____	Yellow Jaundice
_____	_____	_____	Heart Disease
_____	_____	_____	High Blood Pressure
_____	_____	_____	Stroke
_____	_____	_____	Phlebitis
_____	_____	_____	Rheumatic Fever
_____	_____	_____	Lung Disease; Tuberculosis
_____	_____	_____	Asthma
_____	_____	_____	Eczema, Hives, Rashes
_____	_____	_____	Arthritis
_____	_____	_____	Venereal Disease
_____	_____	_____	Smoking, Alcohol, Other (Circle)

List all medications you are now taking:

(If possible copy from label of bottle and include all medicines such as Birth Control, Vitamins, etc)
