JCHC
497 W Lott Buffalo, WY 82834

JOHNSON COUNTY HEALTHCARE CENTER / FAMILY MEDICAL CENTER
PATIENT HEALTH HISTORY FORM

PATIENT: _____ DATE OF BIRTH: _____

DATE OF SERVICE: _____

Please take the time to fill out this questionnaire prior to your appointment. Your answers to all the following questions will help the provider identify your medical history and conditions, and allow more time for discussion during the visit.

Please list your preferred pharmacy.

Pharmacy Name: _____ Phone Number: _____

Are you currently employed? ☐ No ☐ Yes

If yes, what is your occupation? _____

Please list your past medical history (surgeries, injuries and major illness).

PAST PERSONAL INJURY OR ILLNESS/SURGERY	DATE	HOSPITALIZED?

Please list all medications (prescription and non-prescription) that you take. Include herbal remedies, vitamins, over-the-counter, street drugs, prescriptions, etc. If you need more space, please attach list.

MEDICATIONS	DOSAGE	MEDICATIONS	DOSAGE

Do you have any food, environmental, or drug allergies? ☐ NO ☐ YES (Please explain below)

ALLERGY TYPE (medication, food, environment)	ALLERGY (name of medication or food)	REACTION

Do you smoke? Please explain below. ☐ NO, never have ☐ NO, previously have ☐ YES

TYPE OF TOBACCO (cigarette, chew, etc.)	HOW MUCH	HOW OFTEN

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Do you drink alcohol? ☐ NO, never have ☐ NO, previously have ☐ YES

TYPE OF ALCOHOL	HOW MUCH	HOW OFTEN

Any recreational drug uses? ☐ NO, never have ☐ NO, previously have ☐ YES

TYPE OF DRUGS	HOW MUCH	HOW OFTEN

Are you currently treated with pain medication? ☐ Yes ☐ No

Family Medical History:

FAMILY MEMBER	MEDICAL CONDITIONS
Mother	
Father	
Sibling(s)	
Other:	

Vaccines and Immunizations:

VACCINATION / IMMUNIZATIONS	YEAR(S)
Hepatitis B?	
Pneumonia?	
COVID-19?	
Zoster, Shingrix (shingles)?	
Respiratory Syncytial Virus (RSV)?	
Influenza yearly? ☐ Yes ☐ Some years ☐ No	

Procedure History:

TEST / PROCEDURE	DATE (if unsure, estimate year)	RESULT – Abnormal?
Mammogram		
Colonoscopy		
Bone Density Scan (DEXA)		
Pap Smear		
Hep C Screening		
HIV Screening		
Prostate-Specific Antigen (PSA)		

Please list care providers who are outside JCHC (including specialists, eye doctor etc.).

CARE PROVIDERS	SPECIALIST	FACILITY

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Please list any durable medical equipment providers (ex. Oxygen or CPAP companies).

NAME OF COMPANY	TYPE OF DME

Please select one response for each question:

Over the past two weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things:
☐ 0 = Not at all ☐ 1 = Several days ☐ 2 = More than half the day ☐ 3 = Nearly every day

Feeling down, depressed, or hopeless:
☐ 0 = Not at all ☐ 1 = Several days ☐ 2 = More than half the day ☐ 3 = Nearly every day

Total patient score: _____

What is the most important concern you would like addressed at your first appointment?

_____

_____

_____

_____

_____

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