CHAPA-DE
INDIAN HEALTH

Today's Date: _____

Pt. Acct. #: _____

DOB: _____

HEALTH HISTORY FORM

Our office follows written policies and procedures to protect the privacy of your personal information. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. We do not use this information to discriminate.

Legal Name:	I prefer to be called:
What is current gender identity? Male: ___ Female: ___ Other: _____	What was your assigned gender at birth? Male: ___ Female: ___ Other: _____
What language would you prefer to use with us:	
If you are completing this form for another person, what is your relationship to that person? Your Name: Your Relationship:	

Do you have any of the following?	Yes	No	Unsure
One or more signs and symptoms of Tuberculosis (TB) such as prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue			
Close contact with someone with infectious TB disease			
Foreign-born person from any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe			
Traveler to high TB prevalence country for more than one month specifically any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe			
Current or former resident or employee of correctional facility, long-term care facility, hospital, or homeless shelter			
History of positive TB test or TB disease			

If you answered yes to any of the questions above please stop and return this form to the front desk

Medical Information	Yes	No	If yes, please explain
Do you drink caffeine (coffee, tea, soda, energy drinks)?			How many per day _____
Are you pregnant?			If yes, how far along _____
Describe your eating habits (poor, well balanced, vegetarian, gluten-free):			
Date of Last Dental Exam: _____			

SURGICAL HISTORY (Please list all prior operations and dates)

Your Medications
Please list all your medications including injections with dosage and frequency, vitamins (natural or herbal preparations) and/or diet supplements:

ALLERGIES (Please list any medicines, foods other items you are allergic to or have a reaction to)	**Type of Reaction**

Have you had any of the following?	**Yes**	**No**		**Yes**	**No**
Cardiovascular Disease			Emphysema/COPD		
High blood pressure			Coagulation problems/Hemophilia		
Heart attack and when:			Bulimia/Anorexia		
Blood transfusion Date:			Thyroid Problem Type:		
Mental health disorders Type:			Hepatitis/liver disease Type:		
Cancer Type and when:			Neurologic Problem Type:		
Kidney problems			Acid Reflux		
AIDS or HIV Infection			Seasonal allergies		
Rheumatologic Disease (eg Lupus, RA, etc.) Type:			Repaired heart disease with shunts, catheter or regurgitation		
Asthma			Previous infective endocarditis		
Do you have any other disease, condition or problem not listed above that you think we should know about?					

Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my provider and their staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my provider, or any other member of their staff, responsible for any action they take or do not take because of errors or omissions on this form.

Signature of Patient
or Legal Guardian: _____ Date: _____

Signature of Provider: _____ Date: _____