CHICAGOLAND COMPLETE HEALTHCARE

Name: _____

Date of Birth: _____ ☐ Male ☐ Female

RACE (select one):

☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Hispanic

☐ Other Pacific Islander ☐ Other Race ☐ I do not wish to state

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ ☐ Home ☐ Cell May we leave a message? ☐ Yes ☐ No

Email Address: _____

PREFERRED PHARMACY INFORMATION - We electronically transmit prescriptions to pharmacies.

Pharmacy Name _____

Address (or cross streets) _____

EMPLOYMENT INFORMATION

□ Full-Time □ Part-Time □ Self-Employed □ Not Employed □ Retired □ Full-Time Student □ Part-Time Student

Employer _____ Work Phone _____

EMERGENCY CONTACT INFORMATION

Emergency Contact _____ Relationship _____

Phone _____

SOCIAL / PERSONAL HABITS

Do you smoke? ☐ Yes ☐ No If so, how many per day _____ Do you drink alcohol? ☐ Yes ☐ No If so, how many drinks per week _____

Do you exercise regularly? ☐ Yes ☐ No If YES, how many times per week _____

HOSPITALIZATIONS / SURGERIES (Include Date/Year and Type of Illness/ Surgery

_____

_____

CURRENT MEDICATIONS (please include, birth control, vitamins, supplements, OTC)

Name **Dose**

_____

_____

_____

ALLERGIES (food, medication, substances)

_____

_____

_____

PAST MEDICAL HISTORY (please check box if you or relatives have had any of the following):	YOU	MOTHER	FATHER	SIBLINGS	PATERNAL GRAND MOTHER	PATERNAL GRAND FATHER	MATERNAL GRAND MOTHER	MATERNAL GRAND FATHER
Asthma	□	□	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□	□	□
Stroke	□	□	□	□	□	□	□	□
Cancer	□	□	□	□	□	□	□	□
Thyroid Abnormality	□	□	□	□	□	□	□	□
Heart Problem	□	□	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□	□	□
High Cholesterol	□	□	□	□	□	□	□	□
Mental Illness	□	□	□	□	□	□	□	□
Alcohol / Drug Abuse	□	□	□	□	□	□	□	□

GYNECOLOGICAL / OBSTETRIC HISTORY

How many pregnancies?: _____ Births _____ Miscarriages? _____ Other: _____

Have you ever had an abnormal pap smear? ☐ Yes ☐ No

Method of birth control: _____

PREVENTATIVE CARE:	YES	NO	DATE
PAP SMEAR	☐	☐	
Mammogram	☐	☐	
Bone Density (DEXA scan)	☐	☐	
Cholesterol Testing (Lipid Panel)	☐	☐	
TDaP Immunization	☐	☐	
Shingles Immunization	☐	☐	
Pneumonia Immunization	☐	☐	
HPV Immunization	☐	☐	