

Ammonoosuc Community Health Services

ACHS – Littleton 25 Mount Eustis Road Littleton, NH 03561

(603) 444-2464 Fax: (603) 444-5209

Medical History

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Occupation: _____

Past Personal Medical History: *(Please check all that apply)*

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Colitis | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lung cancer |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Colon cancer |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Other cancer _____ |
| <input type="checkbox"/> Heart attack (MI) | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Migraines | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> Herpes |

Other Personal Medical Problems or Hospitalizations:

Past Surgical History: *(Please list type of surgery and approximate date of surgery)*

Type of Surgery	Approximate Date
_____	_____
_____	_____
_____	_____

Family History: *(Please check if any family member has had or has the following – check all that apply)*

<u>Family member(s)</u>	<u>Family member(s)</u>
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Thyroid disorder _____	<input type="checkbox"/> Kidney Stones _____
<input type="checkbox"/> Seizure disorder _____	<input type="checkbox"/> Glaucoma _____
<input type="checkbox"/> Osteoporosis _____	<input type="checkbox"/> Alcoholism _____
<input type="checkbox"/> Rheumatoid Arthritis _____	<input type="checkbox"/> Suicide _____
<input type="checkbox"/> High Cholesterol _____	<input type="checkbox"/> Mental Illness _____
<input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> Depression/Anxiety _____
<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Dementia/Alzheimer’s _____

