# Copper Queen Community Hospital

**Hereford RHC**
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Hereford, AZ 85615
**Phone** (520)432-8220
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**Palominas RHC**
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Tombstone, AZ 85638
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# New Patient Medical History Form

Date: _____

Name: _____ DOB: _____

Address: _____

Phone: _____ E-mail: _____

Marital Status: ☐S ☐M ☐D ☐W Pharmacy: _____

Allergies (Food, Medication, etc.)

| Allergy | Allergic Reaction |
|---|---|
| | |
| | |
| | |
| | |

Medications: (Please list all)

| Name | Dosages | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

If more room is needed to list medications, please us back of this page.

Surgical History:

| Surgery | Date | Facility/ Location |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Women's Health

Date of Last Menstrual Cycle: _____ ☐Normal ☐Abnormal Age of First Menstruation: _____
Age of Menopause: _____ Total # of pregnancies: _____ # Live births: _____
Pregnancy Complications: _____

## Other Health Issues:

*Sexual Activity:*

Are you sexually active? ☐ Yes ☐ No
Birth Control Method: ☐ None ☐ Condom ☐ Pill/Ring/Patch/Injection/IUD ☐ Vasectomy
Do you have children? ☐ Yes ☐ No If yes, how many? _____

*Exercise:*

Do you exercise regularly? ☐ Yes ☐No
What Kind of Exercise? _____Duration: How Long: _____ How often: _____

*Sleep:*

How many hours, on average, do you sleep at night (or during the day, if you work night shift)?_____

*Diet:*

How would you rate your diet? ☐Good ☐Fair ☐Poor Would you like advice on your diet? ☐Yes ☐No

*Safety:*

Do you use a bike helmet? ☐Yes ☐No Do you use seat belts consistently? ☐Yes ☐No
Working smoke detector in home? ☐Yes ☐No If you have guns at home, are they locked up? ☐Yes ☐No
Is violence at home a concern for you? ☐Yes ☐No
Have you completed an Advanced Directive for Health Care (ADHC), Living Will, or Physical Orders for Life Sustaining Therapy (POLST)? ☐Yes ☐No

## Other Providers/Specialist:

| Provider | Name | Last Visit |
|---|---|---|
| Cardiology | | |
| Gastroenterologist (GI) | | |
| OB/GYN | | |
| Neurology | | |
| Pulmonology | | |
| Nephrology | | |
| Hematology | | |
| Other | | |

## Health Maintenance Screening Test History

| Testing | Date | Provider | Abnormal Results |
|---|---|---|---|
| Cholesterol | | | ☐Yes ☐No |
| Colonoscopy | | | ☐Yes ☐No |
| Mammogram | | | ☐Yes ☐No |
| WWE/PAP | | | ☐Yes ☐No |

| | | | |
|---|---|---|---|
| Bone Density | | | ☐Yes ☐No |
| A1c | | | ☐Yes ☐No |
| Other | | | ☐Yes ☐No |

## Vaccination History

| | | |
|---|---|---|
| Flu: | Td/Tdap: | Pneumonia: |
| Shingles: | COVID: | Other: |

## Personal Medical History: check all that apply.

| Disease/Condition | Current | Past | Comments |
|---|---|---|---|
| Alcoholism/Drug Abuse | | | |
| Tobacco Use: How Often_____<br>Type: ☐ Cigarettes ☐ Chew ☐ Vape | | | |
| Asthma | | | |
| Cancer (Type_____) | | | |
| Depression/Anxiety/Bipolar/Suicidal | | | |
| Diabetes (Type_____) | | | |
| Emphysema (COPD) | | | |
| Heart Disease | | | |
| High Blood Pressure (Hypertension) | | | |
| High Cholesterol | | | |
| Hypothyroidism/Thyroid Disease | | | |
| Renal/Kidney Disease | | | |
| Migraine Headaches | | | |
| Stroke | | | |
| Other: | | | |

## Family History

| Member | Age Deceased | Condition |
|---|---|---|
| Father | | |
| Paternal Grandfather | | |
| Paternal Grandmother | | |
| Mother | | |
| Maternal Grandfather | | |
| Maternal Grandmother | | |
| Other | | |

## Additional Information:

Have you traveled outside of the country in the last 30 days? ☐ Yes ☐ No If yes, Where?_____

Have you served in the military? ☐ Yes ☐ No If yes, how long, and what branch?_____

Were you deployed? ☐ Yes ☐ No If yes, Where?_____