Copper Queen Medical Associates

Hereford RHC
4524 E. Hereford Rd.
Hereford, AZ 85615
Phone (520)432-8220
Fax (520)432-8215

Palominas RHC
10524 E. Hwy 92
Palominas, AZ 85615
Phone (520)366-0300
Fax (520)366-0440

Tombstone RHC
7 N. San Diego St.
Tombstone, AZ 85638
Phone (520)432-6460
Fax (520)457-1485

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_____ 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?_____