Community CARE CLINIC of Dare

Patient History

Please Print

For CCCD Use	ID#:
❑ One Time Only	❑ Full Certification
Entered in MS?	Date & Initials

Today's Date: _____

First: _____ Middle: _____ Last _____

Date of Birth_____/_____/ Age: _____ Sex: ❑ Male ❑ Female

Reason for Visit Today: _____

Past Medical History (Please check if you have had any of the following):

High Blood Pressure	❑ yes ❑ no	If yes, year of diagnosis _____
High Cholesterol	❑ yes ❑ no	If yes, year of diagnosis _____
Diabetes	❑ yes ❑ no	If yes, year of diagnosis _____
Asthma	❑ yes ❑ no	If yes, year of diagnosis _____
Heart Disease	❑ yes ❑ no	If yes, year of diagnosis _____
Cancer	❑ yes ❑ no	If yes, year of diagnosis _____ Where _____

Other Medical Conditions:

_____

_____

_____

Drug Allergies (Please list all allergies):

_____

_____

_____

Past Surgical History (Please list surgeries and dates):

_____

_____

_____

Social History:

Smoking	❑ yes ❑ no	If yes, how many per day _____ _____
Alcohol	❑ yes ❑ no	If yes, how many per day _____ _____
Drug Use	❑ yes ❑ no	If yes, what and how much _____

Current Medications:

Medication	Dosage	# Times Taken Per Day

Where did you receive medical care in the last year?

Name of Doctor or Facility	Address / City / State