DHCHD
Dallam Hartley Counties
Hospital District

1411 Denver Avenue
Dalhart, Texas 79022
www.dhchd.or

# HIGH COUNTRY RURAL HEALTH CLINIC

**320 E. Texas Blvd. DALHART, TEXAS 79022**

**Phone: (806) 244-8324 Fax: (806) 249-8412**

**Medical History**

(please mark those that apply)

| | | | | | |
|---|---|---|---|---|---|
| Angina/Chest Pain | | GERD (reflux) | | Osteoarthritis | |
| Coronary Artery Disease | | Irritable Bowel Syndrome (IBS) | | Rheumatoid arthritis | |
| Valvular Heart Disease | | Crohn's Disease (IBD) | | Gout | |
| Arrhythmias (Afib, WPW, etc) | | Ulcerative Colitis (IBD) | | Osteoporosis | |
| Hypertension | | Pancreatitis | | Fibromyalgia | |
| Hyperlipidemia | | Peptic Ulcer Disease | | Chronic low back pain | |
| Congestive Heart Failure | | Gastritis | | Chronic Joint Pain (please specify): | |
| Abdominal Aneurysm | | Hemorrhoids | | | |
| History of MI | | Chronic Constipation | | | |
| Peripheral Vascular Disease | | Fecal Incontinence | | | |
| Syncope | | Hepatitis | | Hearing loss | |
| | | Fatty Liver | | Glaucoma | |
| Diabetes Mellitus | | Abnormal Colonoscopy (please specify): | | Cataracts | |
| Hypothyroidism | | | | Vision loss | |
| Hyperthyroidism | | | | | |
| | | | | Acne | |
| Anemia | | Headaches | | Eczema | |
| Bleeding Disorder | | Stroke (CVA) or TIA | | Psoriasis | |
| Clotting Disorder | | Seizures/Epilepsy | | | |
| Thrombocytopenia | | Peripheral Neuropathy | | | |
| Deep Vein Thrombosis (DVT) | | Restless Leg Syndrome | | Chickenpox | |
| Pulmonary Embolism (PE) | | Dementia | | HIV/AIDS | |
| | | Parkinson's Disease | | MRSA | |
| COPD | | Multiple Sclerosis | | Tuberculosis/Abnormal PPD (please specify): | |
| Asthma | | | | | |
| Sleep Apnea | | Depression | | Rubella | |
| | | Anxiety | | Polio | |
| Chronic Kidney Disease | | Bipolar Disorder | | Mumps | |
| Urinary incontinence | | Anorexia | | Measles | |
| Kidney Stones | | Bulimia | | Rheumatic fever | |
| Recurrent UTI | | Schizophrenic | | | |
| Interstitial Cystitis | | ADD/ADHD | | | |
| Hematuria | | Autism Spectrum Disorder | | | |
| | | Learning delay | | | |
| Cancer (specify type): | | Other (please specify): | | | |

**Please be sure to continue to next page…**

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**Surgical History**

| | Date | | Date | | Date |
|---|---|---|---|---|---|
| Tonsillectomy | | Cholecystectomy | | Mastectomy | |
| Dental Surgery | | Appendectomy | | Lumpectomy | |
| Heart Cath | | Splenectomy | | Breast biopsy | |
| Coronary Stent | | Colonoscopy | | | |
| CABG | | Bowel resection | | Skin cancer removal | |
| Pacemaker/Defibrillator | | Hernia repair | | | |
| Valve Replacement | | Gastric bypass | | Cesarean Section | |
| Thyroidectomy | | Bladder Surgery | | Bilateral Tubal Ligation | |
| Parathyroidectomy | | Kidney Surgery | | Hysterectomy | |
| Spine Surgery (please specify): | | Joint replacement (please specify): | | Ovary removal | |
| | | | | LEEP | |
| | | | | D&C | |
| Other (please specify): | | | | | |

**Family History**

(please mark those that apply)

| | Father | Mother | Sibling | Children | Maternal Grandma | Maternal Grandpa | Paternal Grandma | Paternal Grandpa |
|---|---|---|---|---|---|---|---|---|
| Diabetes Mellitus | | | | | | | | |
| Thyroid disease | | | | | | | | |
| Hypertension | | | | | | | | |
| Hyperlipidemia | | | | | | | | |
| Coronary Artery Disease | | | | | | | | |
| Congestive Heart Failure | | | | | | | | |
| Heart attack (MI) | | | | | | | | |
| Arrhythmia | | | | | | | | |
| Stroke | | | | | | | | |
| Dementia | | | | | | | | |
| Asthma/COPD | | | | | | | | |
| Bleeding disorder | | | | | | | | |
| Clotting disorder | | | | | | | | |
| Autoimmune disorder | | | | | | | | |
| Depression | | | | | | | | |
| Addiction | | | | | | | | |
| Kidney Disease | | | | | | | | |
| Cancer (please specify): | | | | | | | | |
| Other (please specify): | | | | | | | | |

**Please be sure to continue to next page…**

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**OB/GYN History (females only)**

Age Periods Started:_____ Age Periods Stopped: _____

Last Menstrual Period:_____Average length of period:_____Average length between periods: _____

# of Pregnancies:_____ # of miscarriages:_____ # of live births: _____

Birth Control Method: _____

Last Pap Smear (date/results): _____

Last Mammogram (date/results): _____

**Current Medications:** (please include any over the counter medications & herbal supplements)

| Medication Name | Strength | Frequency | Medication Name | Strength | Frequency |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Preferred Pharmacy:** _____

**Allergies** (medications, food, environmental, etc.)

_____

_____

_____

_____

**Social History**

Tobacco Use: Current: YES NO If yes, how many packs per day?_____ How long?_____

Past: YES NO when did you quit?_____ Secondhand exposure: YES NO

Alcohol Use: YES NO If yes, how much/often? _____

Substance Use: □ None □ Marijuana □ Opiates □ Cocaine □ Heroin □ Amphetamines □ Hallucinogens
□ Other (please specify): _____

Preferred Language:
□ English □ Spanish □ Other: _____

**The information given in this medical history is accurate to the best of my knowledge.**

**Signature:**_____ **Date:** _____

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## ADULT MEDICAL INFORMATION

Name:_____DOB:_____Date:_____

**Please answer all questions completely and to the best of your knowledge.**

**PAST MEDICAL HISTORY:** (Check conditions you **have** or **have had** in the past.)

| | | | |
|---|---|---|---|
| ____Anemia | ____Anorexia | ____Appendicitis | ____Arthritis |
| ____Asthma | ____Bleeding disorders | ____Blood transfusion | ____Breast lump |
| ____Bronchitis | ____Bulimia | ____Cancer | ____Chicken pox |
| ____Diabetes | ____Epilepsy | ____Heart Attack | ____Heart disease |
| ____Hepatitis | ____Hernia | ____Herpes | ____High blood pressure |
| ____HIV positive | ____Kidney disease | ____Measles | ____Migraine headaches |
| ____Mononucleosis | ____Mumps | ____Pneumonia | ____Polio |
| ____Prostate problems | ____Psychiatric care | ____Rheumatic fever | ____Scarlet fever |
| ____Suicide attempt | ____Thyroid problems | ____Tuberculosis | |

Please list any other **ongoing medical problems** and their approximate start date.

_____
_____
_____
_____

Please list all **operations** and **significant illnesses** Along with approximate dates.

_____
_____
_____
_____

OB/GYN History (female only):

Age of first period_____yrs. Old Number of pregnancies_____ Number of children_____

Last mammogram_____ Ever abnormal? No/Yes If yes, what treatment?_____

Last pap_____ Ever abnormal? No/Yes If yes, what treatment?_____

Last menstrual period started_____OR Date of menopause_____

Cycle length_____days Date of surgical hysterectomy_____

Heaviness of menstrual flow Hvy / Med / Light Reason for hysterectomy_____

Type of birth control used_____

**MEDICATIONS:** (please list all your **current medications** and doses, include over the counter meds & supplements taken regularly)

_____
_____
_____

**PREFERRED PHARMACY:**_____

**MEDICATIONS ALLERGIES:**_____

**OTHER ALLERGIES:**_____

**IMMUNIZATION HISTORY:** (Please list date of last immunization and provide a copy of your childhood immunization record)

Tetanus booster _____

Influenza (flu shot) _____

Pneumovac (pneumonia shot)_____

Hepatitis B series _____

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**FAMILY HISTORY:** (please circle any diseases that run in your family and list relatives affected)

| | | | |
|---|---|---|---|
| Arthritis | _____ | Gout | _____ |
| Autoimmune disease | _____ | Heart disease | _____ |
| Bleeding disorder | _____ | High blood pressure | _____ |
| Cancer | _____ | Kidney disease | _____ |
| Congenital defects | _____ | Lung disease | _____ |
| Diabetes | _____ | Mental Illness | _____ |
| Epilepsy | _____ | Stroke | _____ |
| GI disorder | _____ | Tuberculosis | _____ |

Other: _____

**SOCIAL HISTORY:** (please fill in blanks and circle the most accurate answers as appropriate)

How often do you use **tobacco**? Never / Rarely / Occasionally / Daily_____ per day Type: Cig/ Cigar/ Pipe/ Snuff/ Chew
How often do you drink **caffeinated drinks**? Never/ Rarely/ Occasionally/ Daily _____ per day
How often do you **exercise**? Never/ Rarely/ Occasionally/ Daily_____per day

How often do you drink **alcohol**? Never/ Rarely/ Occasionally/ Daily_____per day
How often do you use **illegal drugs**? Never/ Rarely/ Occasionally/ Daily_____ per day

**REVIEW OF SYMPTOMS:** (please circle any symptoms you currently have or have had in the recent past)

**GENERAL:** Chills. Depression. Dizziness. Fainting. Fever. Forgetfulness. Headache. Loss of sleep. Loss of weight. Weight gain. Nervousness. Numbness. Sweats.

**MUSCLE/JOINT/BONE**: Pain. Weakness or numbness in: Arms. Back. Neck. Hips. Legs. Feet. Shoulders. Hands

**GENITOURINARY:** Blood in urine. Frequent urination. Lack of bladder control. Painful urination. Erection difficulties
Lump in testicles. Penile discharge. Sore on penis. Vaginal discharge. Painful intercourse. Bleeding between periods. Excessive bleeding with periods.

**CARDIOVASCULAR:** Chest pain. High blood pressure. Irregular heart beat. Low blood pressure. Poor circulation. Rapid heart beat. Swelling of ankles. Varicose veins. Shortness of breath. Shortness of breath with exertion. Murmur. Palpitations. Sleeping on multiple pillows.

**RESPIRATORY:** Cough. Shortness of breath. Wheezing. Sputum production. Coughing of blood.

**HEENT:** Bleeding gums. Blurred vision. Crossed eyes. Difficulty swallowing. Double vision. Earache. Ear discharge. Seeing spots. Runny nose. Sneezing. Itching, watery eyes. Burning eyes. Hoarseness. Loss of hearing. Nose bleeds. Ringing in ears. Sinus problems.

**SKIN:** Bruise easily. Hives. Itching. Change in moles. Rash. Sore that won't heal. Swelling. Color change.

**NEUROLOGIC:** Memory loss. Tremors. Fainting. Dizziness. Seizures. Headaches. Confusion. Difficulty speaking.

**PSYCHOLOGICAL:** Depression. Anxiety. Thoughts of suicide. Hallucinations. Paranoia. Mood swings.

**The information given in this medical history is accurate to the best of my knowledge.**

**Signature:**_____ **Date:**_____

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## CHILD MEDICAL HISTORY

**(To be completed by parent or guardian)**

Child's Name:_____DOB:_____Date:_____

**Please answer all questions completely and to the best of your knowledge.**

**BIRTH HISTORY:**

Child delivered at Term (9mths) Premature by____wks. Late by____wks.

Child delivered by Normal vaginal delivery OR C-Section Birth weight _____lbs____oz. Length_____

Complications at birth or during pregnancy?_____

**PAST MEDICAL HISTORY**: (Check conditions child has or has had in the past.)

| | | | |
|---|---|---|---|
| ____Acne | ____ADHD | ____Allergies | ____Anemia |
| ____Asthma | ____Behavior problems | ____Bleeding disorders | ____Bronchitis |
| ____Bulimia | ____Cancer | ____Cataracts | ____Chemical dependency |
| ____Chicken pox | ____Developmental delay | ____Diabetes | ____Eczema (atopic dermatitis) |
| ____Epilepsy | ____Heart disease | ____Heart failure | ____Hepatitis |
| ____Hernia | ____High blood pressure | ____High cholesterol | ____HIV positive |
| ____Kidney disease | ____Learning disability | ____Liver disease | ____Measles |
| ____Pneumonia | ____Polio | ____Premature birth | ____Psoriasis |
| ____Psychiatric care | ____Rheumatic fever | ____Tubes in ears | ____Urinary tract infection |

Please list any other **ongoing medical problems** and there approximate start date.

_____

_____

_____

Please list all **operations, hospitalizations, and Significant illness** along with approximate dates.

_____

_____

_____

Please list any other Physicians or Healthcare providers your child sees, and the reason seen:_____

_____

**MEDICATIONS:** (Please list all current medications and doses, include over the counter meds & supplements taken regularly)

_____

_____

**MEDICATION ALLERGIES:** (please list)_____

_____

**OTHER ALLERGIES:** (please list)_____

_____

**IMMUNIZATION HISTORY** (please list date of last immunization and provide a copy of immunization record)

Tetanus booster_____ Flu shot_____ Pneumonia vaccine_____

Hepatitis B series_____ Chicken pox vaccine_____or approx date of Chicken pox_____

**I AUTHORIZE THE FOLLOWING PERSON(S) TO BRING MY CHILD, AS NAMED ABOVE, TO HCCRHC FOR TREATMENT ON MY BEHALF.**

_____ _____

**Name of authorized person Relationship to child** **Name of authorized person Relationship to child**

_____

**Signature of parent or guardian Date**

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**GYN HISTORY:** (only if already had first menses)

Age of first period_____ yrs old
Last menstrual period started _____
Cycle length_____days (regular / irregular)
Heaviness of menstrual flow Hvy / Med / Light

**FAMILY HISTORY:** (please circle any diseases that run in your family and list relatives affected)

Arthritis_____
Asthma_____
Autoimmune_____
Bleeding disorder_____

Birth defects_____
Cancer_____
Diabetes_____
Epilepsy_____
GI disorder_____
Heart disease_____
Kidney disease_____
Lung disease_____
Mental illness_____
Tuberculosis_____
Other_____

_____

**REVIEW OF SYMPTOMS:** (please skip this section if child is less than two years old.)

**Please circle any symptoms your child currently has:**

**GENERAL:** Chills. Depression. Dizziness. Fainting. Fever. Forgetfulness. Headache. Loss of sleep. Loss of weight. Weight gain. Nervousness. Numbness. Sweats.

**MUSCLE/JOINT/BONE:** Blood in urine. Frequent urination. Painful urination. Lack of bladder control. Bed wedding.

**GASTROINTESTINAL:** Poor appetite. Bloating. Bowel changes. Constipation. Diarrhea. Excessive hunger. Excessive thirst. Gas. Nausea. Rectal bleeding. Stomach pain. Soiling of underpants. Vomiting. Vomiting blood.

**CARDIOVASCULAR:** Chest pain. Irregular heart beat. Rapid heartbeat. Shortness of breath with exertion. Murmur. Palpitations.

**RESPIRATORY:** Cough. Shortness of breath. Wheezing. Sputum production. Coughing of blood.

**HEENT:** Bleeding gums. Crossed eyes. Difficulty swallowing. Double vision. Earache. Ear discharge. Runny nose. Sneezing. Itching. Watery eyes. Burning eyes. Hoarseness. Loss of hearing. Nose bleeds. Ringing in ears. Sinus problems. Blurred vision. Glasses or Contacts.

**SKIN:** Bruise easily. Hives. Itching. Rash. Sore that won't heal. Swelling.

**NEUROLOGIC:** Fainting. Dizziness. Seizures. Headaches. Confusion. Concussion.

**PSYCHOLOGICAL:** Depression. Anxiety. Thoughts of suicide. Hallucinations. Paranoia. Mood swings.

**The information given in this medical history is accurate to the best of my knowledge.**

_____ _____ _____

**Signature** **Relationship to child** **Date**

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**Patient acknowledgement that you read and can receive a copy of our HIPPA Privacy Practices dated September 23, 2013.**

Patient Name:_____ Date of Birth: _____

- ϒ I do NOT authorize any information to be discussed with any family members or friends.
- ϒ I authorize information about treatment or appointments to be discussed with the following

Person(s): _____

I have read and understand the above information.

_____ _____

Patient/Guardian Signature Date

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**DRAFT CHOICE OF LAW AND FORUM CLAUSE**

**NONEMERGENCY**
AGREEMENT AS TO GOVERNING LAW AND FORUM

The patient, including patient's representative and heirs or beneficiaries, and the health care provider, including employees and agents of the health care provider, rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree:

1. That all health care rendered shall be governed exclusively and only by Texas law, and in no event shall the law of any other state apply to any health care rendered to patient; and
2. In the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall be brought only in a Texas court in the county/district where all or substantially all of the health care was provided or rendered, and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Signature of Patient Date

**NO ES DE EMERGENCIA**
ACUERDO CON RESPETO A LA LEY APLICABLE Y FORO:

El paciente, incluyendo el representante del paciente, y herederos o beneficiarios, y el proveedor de cuidado de la salud, incluyendo a los empleados y agentes del proveedor de atención médica, la prestación o la prestación de asistencia médica, cuidados de la salud, o servicios de seguridad o profesionales o administrativos directamente relacionados con la atención sanitaria a los pacientes de acuerdo de:

1. Que todo cuidado de la salud se regirán exclusivamente y sólo por la Ley de Texas y en ningún caso la ley de cualquier otro estado aplicará a cualquier cuidado de la salud prestada al paciente; y
2. En el caso de una disputa, cualquier demanda, acción o causa que de alguna manera se relaciona con el cuidado de la salud proporcionado al paciente sólo será llevada en un tribunal de Texas en el condado / distrito donde todo o sustancialmente todo cuidado de la salud fue prestada o proporcionada y en ningún caso cualquier demanda, acción o causa de acción nunca será llevada en cualquier otro estado. La elección de las disposiciones legales y selección de foro de este párrafo son obligatorios y no son permisivas.

Signature of Patient Date

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## NOTICE OF FINANACIAL RESPONSIBILITY

Patient's name:_____ Date of Birth:_____

I_____(parent /guardian/ responsible party's name) have been notified by clinic staff (physician/provider) that my insurance_____may deny payment of certain health care services. If my insurance denies payment I understand that I will be personally and fully responsible for payment of services rendered. I also understand that I can personally appeal or discuss such denial of coverage with my insurance company and that covered services may change at any time without notification due to me.

_____ _____
Patient signature (Guardian if minor) Date

_____ _____
Witness/Clinic Staff signature Date