



Horizon View Medical Center

Phone # (702) 641-8500 Fax # (702) 641-8502

PATIENT CHART: _____

DOB: _____ AGE: _____ SEX: _____ ACCOUNT: _____

FAMILY MEDICAL HISTORY

Please check all that apply, include age of onset	Mother	Father	Siblings	Children
Alzheimer's Disease				
Abdominal Aortic Aneurysm				
Blood Clots				
Breast Cancer				
Colon Polyps				
Prostate Cancer				
Lung Cancer				
Other Cancer				
Coronary Artery Disease, Premature				
Crohn's				
Diabetes				
Epilepsy				
Heart Disease				
Hemachromatosis				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Lung Disease				
Lupus				
Melanoma				
Osteoporosis				
Psychiatric Disorder				
Rheumatoid Arthritis				
Seizures/Epilepsy				
Stroke				
Thyroid Disorder				
Ulcerative Colitis				



Horizon View Medical Center

PATIENT CHART: _____

DOB: _____ **AGE:** _____ **SEX:** _____ **ACCOUNT:** _____

List any other major illnesses, surgeries, treatments or conditions: _____

PAST MEDICAL HISTORY

Have you ever had?	Yes	No
Abnormal Heart Rhythm		
Asthma		
Blood Problem		
Cancer		
Diabetes		
Heart Attack		
Heart Failure		
Hepatitis		
High Blood Pressure		
High Cholesterol		
Kidney Problem		
Liver Problems		
Sleep Apnea		
Thyroid Problems		
Tuberculosis		
Ulcer or Gastritis		
Other: _____		

Have you ever had?	Yes	No	If Yes, Please Explain
Have you ever had serious illness?			
Have you ever had a transfusion?			When: _____
Have you ever been hospitalized or been under medical care for very long?			



Horizon View Medical Center

PATIENT CHART: _____

DOB: _____ **AGE:** _____ **SEX:** _____ **ACCOUNT:** _____

Injuries?	Yes	No	If Yes, Please Explain
Have you ever been seriously injured in a motor vehicle accident?			
Have you had any head concussions or injuries?			
Have you ever been knocked unconscious?			

SOCIAL HISTORY

Check One - Single: _____ Married: _____ Widowed: _____ Divorced: _____

Lives With: _____

History	Yes	No	Order	Specifics
Tobacco Use			Type Frequency Quantity Duration Quit Date	Cigarettes ____ Cigars ____ Chewing ____ Other _____
Drug Use			Type Frequency Quantity Duration Quit Date	Prescription ____ Illicit ____ Specific Type(s) _____



Horizon View Medical Center

PATIENT CHART: _____

DOB: _____ **AGE:** _____ **SEX:** _____ **ACCOUNT:** _____

History	Yes	No	Order	Specifics
Alcohol Use			Type Frequency Quantity Duration Quit Date	Beer ___ Wine ___ Hard Liquor ___ Other _____
Sexual History			Notes	
Work History			Occupation Hazardous Exposure	Yes ___ or No ___ If Yes, Please Explain _____ _____ _____

Other	Hobbies Pets Travel	
-------	---------------------------	--