

# COMMUNITY OF HOPE FREE HEALTH CLINIC

## PATIENT INFORMATION FORM

(Please Print Legibly & Fill in ALL Information as Possible)

DATE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ SS# \_\_\_\_\_

NAME: \_\_\_\_\_  
(Last) (First)

ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Or check this box if Homeless:

CELL PHONE: \_\_\_\_\_ OTHER PHONE: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

Would you like Portal access to view your chart?  Yes  No

Do we have your permission to text information to you?  Yes  No

AGE: \_\_\_\_\_ GENDER: \_\_\_\_\_

RACE:  Arab  Asian  Black/African American  Native American  White/Caucasian  
 Mixed Race  Other: \_\_\_\_\_

ETHNICITY:  Hispanic/Latino or  Non-Hispanic/non-Latin origin

PRIMARY LANGUAGE SPOKEN: \_\_\_\_\_ PRIMARY READING LANGUAGE: \_\_\_\_\_

DO YOU NEED A TRNASLATOR? YES \_\_\_\_\_ NO \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_

VETERAN: YES \_\_\_\_\_ NO \_\_\_\_\_ HEAD OF HOUSEHOLD: YES \_\_\_\_\_ NO \_\_\_\_\_

(Only used to show overall demographics of our patients in order to apply for grants)

TOTAL # IN HOUSEHOLD: \_\_\_\_\_

ANNUAL PERSONAL INCOME: \_\_\_\_\_ ANNUAL HOUSEHOLD INCOME: \_\_\_\_\_

EMPLOYED/UNEMPLOYED: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

MEDICAL INSURANCE STATUS: (Your insurance will NOT be charged; information needed for referrals only)

No health insurance

Yes:  Medicaid  Medicare  CareNet  Other: \_\_\_\_\_

If yes, what is the ID number? \_\_\_\_\_

DO YOU HAVE A HEALTH CARE PROVIDER:  No  Yes, their name is: \_\_\_\_\_

PHARMACY OF CHOICE: \_\_\_\_\_ HOSPITAL: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_

Their phone number: \_\_\_\_\_ Their relationship to you: \_\_\_\_\_

WHAT BRINGS YOU TO THE CLINIC TODAY? \_\_\_\_\_

HOW DID YOU HEAR ABOUT THE CLINIC? \_\_\_\_\_

**SOCIAL DETERMINANTS OF HEALTH:**

1. In the past year, have you or any family members you live with been unable to get food  
YES \_\_\_\_\_ NO \_\_\_\_\_
2. Are you worried about losing your housing?  
YES \_\_\_\_\_ NO \_\_\_\_\_
3. Do you feel financially strained to make your ends meet?  
YES \_\_\_\_\_ NO \_\_\_\_\_
4. Has lack of transportation kept you from medical appointments, meetings, work, or getting things needed for daily living?  
YES \_\_\_\_\_ NO \_\_\_\_\_

**\*If you have answered yes to any of these questions, please ask our receptionist for an Assistance Referral Form or speak with one of our nurses.**

**ALLERGIES:**

Updated 07/12/2025

To Medication: \_\_\_\_\_

To foods: \_\_\_\_\_

Other allergies: \_\_\_\_\_

**MEDICAL HISTORY (circle if applicable)**

<b>CARDIAC</b>	<b>ENDOCRINE</b>	<b>SEXUALLY TRANSMITTE DISEASES</b>
Heart Disease	Diabetes (type)	HIV/AIDS
Heart Attack/Stroke	Thyroid	Chlamydia
Heart Valve Problems	PCOS	Gonorrhea
High Blood Pressure	OTHER	Trichomoniasis
High Cholesterol		Syphilis
Heart Arrythmias (A-fib)		Herpes
OTHER		

<b>OTHER CONDITIONS</b>	<b>BEHAVIORAL/MENTAL HEALTH</b>	<b>RESPIRATORY</b>
ARTHRITIS	Anxiety	Chronic Cough
MIGRAINES	Bipolar Disease	Shortness of Breath
HEARTBURN (GERD)	Depression	Bronchitis
Ulcers	Post Traumatic Stress	Asthma
Urinary Problems	ADHD	Emphysema (COPD)
Vision Problems	Other	Other
Other		

**WOMEN'S HEALTH:**

Last menstrual Period \_\_\_\_\_

Date of last PAP \_\_\_\_\_

Current Birth Control \_\_\_\_\_

Date of last Mammogram \_\_\_\_\_

Number of live births \_\_\_\_\_

Number of miscarriages/abortions \_\_\_\_\_

Have you started menopause? \_\_\_\_\_

Any menstrual problems? \_\_\_\_\_