

West Caldwell Health Council, Inc.

Collettsville Medical Center
4330 Collettsville Rd
Collettsville, NC 28611

Tel: (828) 754-2409 Fax: (828) 754-2418

Happy Valley Medical Center
1345 NC Highway 268
Lenoir NC 28645

Tel: (828) 754-6850 Fax: (828) 757-3214

Patient Information:

Name (Last, First, Middle): _____

Preferred Name: _____

Physical/Street Address: _____

Mailing Address if Different: _____

City/State/Zip: _____

Gender:

____ Male
____ Female
____ Unidentified

Gender Identity:

____ Male ____ Transman
____ Female ____ Transwoman
Other (Specify): _____

Sexual Orientation:

____ Straight ____ Bisexual
____ Gay/Lesbian ____ Unknown
Other (Specify): _____

Social Security Number: _____ Date of Birth: _____

Marital Status: ____ Single ____ Married ____ Separated ____ Widowed ____ Divorced

Home Phone: _____ Work Phone: _____ Cell/Alt Phone: _____

Note: Phone numbers will be used for reminder calls.

Email Address: _____

Note: This email address will be used for patient satisfaction surveys and patient portal updates.

Highest Level of Education (Last grade completed): _____

Additional Information:

Race (Choose One): ____ American Indian/Alaska Native ____ Asian ____ Black/African American
____ Native Hawaiian/Other Pacific Islander ____ White ____ Two or more Races

Ethnicity (Choose One): ____ Hispanic ____ Non-Hispanic

Preferred Language: ____ English ____ Spanish Other (Specify): _____

OR I choose not to report Demographic Information. _____ (Initial here)

Insurance Information:

Do you have Medical Insurance? (Circle One) YES NO

Primary Insurance Carrier: _____

Do you have Secondary Medical Insurance? (Circle One) YES NO

Secondary Insurance Carrier: _____

Are you covered by a Drug Plan? (Circle One) YES NO

West Caldwell Health Council Inc. offers a Discounted Services Program to low income individuals who qualify.

Would you like information about this program? (Circle One) YES NO

West Caldwell Health Council Inc. offers a Medication Assistance Program to low income individuals who qualify.

Would you like information about this program? (Circle One) YES NO

Signature of Patient, Parent or Guardian, or Health Care Power of Attorney

Date

West Caldwell Health Council, Inc.

Collettsville Medical Center
PO Box 9
Collettsville, NC 28611
828-754-2409



Happy Valley Medical Center
PO Box 319
Patterson, NC 28661
828-754-6850

MEDICAL & FAMILY HISTORY

Full Name:	Date of Birth:
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PAST MEDICAL HISTORY

Anxiety	Diarrhea	High Blood Pressure	Stroke
Appetite changes	Dizziness/ Fainting	Kidney Stones	Swallowing Difficulty
Asthma	Eating Disorders	Lactose Intolerance	Swelling of joints
Breathing Difficulty	Ears (ringing)	Mental Illness	Tremors
Bleed / Bruise Easily	Fatigue (chronic)	Migraine Headaches	Thyroid Disorder
Cancer (describe)	Gout	Muscle Weakness	Ulcers - stomach
Chest Pain	Heartburn	Nausea/ Vomiting	Urinary problems (desc)
Constipation	Heart Murmur	Numbness hand /feet	Varicose veins
Cough - chronic	Hemorrhoids	Pain (describe)	Visual problems
Depression	Hernia	Seizures	Weight change
Diabetes	Hepatitis	Sleep Apnea	Wounds (legs heal poor)

DESCRIPTION / COMMENTS:

Blood transfusion in past	Dental issues	Implantable Devices	Moles that have changed
Are you sexually active	Birth control method	Number of pregnancies	Date last period

HOSPITALIZATIONS	SURGICAL PROCEDURES
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LIFESTYLE HABITS

Substance Use	Alcohol (started when/how often)	Tobacco Use(began / how often)
Caffeine Use	Diet: Regular, Low Salt, Low Fat, Diabetic	Exercise

MEDICATIONS / ALLERGIES – use back of sheet if more space is needed

Name	Dose/ Strength	Name	Dose / Strength
Allergies (medication/ food/ latex)	Reactions		

FAMILY HISTORY

	Parent	Grand parent	Sibling		Parent	Grand parent	Sibling
Asthma (Z82.5)				High Blood Pressure (Z84.89)			
Cancer (describe) (Z80.?)				Kidney Disease (Z84.1)			
Diabetes (Z83.3)				Mental Illness (Z81.8)			
Glaucoma (Z83.511)				Stroke (Z82.3)			
Heart Disease (Z82.49)				Substance Abuse (Z81.?)			

Patient / Guardian Signature: _____ Date: _____