

**Health History Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **In order to help us better treat you, please complete the information below.**  **We will ask for an updated copy of this form once each year.** | | | |
| **CARDIAC**  Angioplasty/Stent/CABG  Atrial Fibrillation  Bleeding Disorder  Blood Disease  Congestive Heart Failure  Heart Attack  High Blood Pressure  Irregular Heart Beat  Pacemaker/Defibrillator  Murmur  Valve Replacement  Surgery  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reviewed:\_\_\_  **ENDOCRINE**  Diabetes  Thyroid Problems  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reviewed:\_\_\_  **GASTROINTESTINAL**  Acid Reflux  Ulcer  Stomach Problems  Black Stools  Sores on Lip or in Mouth  Ulcers  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reviewed:\_\_\_ | **GENITOURINARY**  Kidney Disease  Kidney Stones  Blood in Urine  Sexually Transmitted Disease  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reviewed:\_\_\_ | | **MISCELLANEOUS**  Alcoholism  Anemia  Arthritis  Attempted Suicide  Blood Clot  Breast Feeding  Cancer/Tumor  Chronic Pain  Drug Abuse  Glaucoma  Growths  Hepatitis B or C  HIV/AIDS  Mumps/Measles/Chicken Pox  MRSA/VRE  Physical Handicap/ Disability  Radiation Treatment  Rheumatic Fever  Rheumatoid Arthritis  Scarlet Fever  Sickle Cell Disease  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reviewed:\_\_\_  **HOSPITALIZATIONS AND/OR SURGERIES** (Please list below)  Reviewed:\_\_\_ |
| **NEUROLOGICAL**  Chronic Headaches  Concussion/Brain Injury  Fainting Spells/Dizziness  Head Injuries  Mental/Nervous Disorders  Anxiety/ Panic Attacks  Depression  Seizures  Stroke/TIA  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reviewed:\_\_\_  **RESPIRATORY**  Asthma  COPD/Emphysema  Hay Fever  Sinus Problems  Hives  Tuberculosis  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reviewed:\_\_\_ | |
| **MEDICAL ALERTS (**Please check all that apply)  Allergic to Penicillin  Allergic to Codeine  Pre-Medication required  AIDS, HIV, AIDS-related Conditions  Allergic to Tetracycline  Allergic to ‘Novocaine’  Mitral Valve Prolapse\*  Hepatitis \_\_\_ (Please list type)  Allergic to Aspirin  Allergic to Latex  Heart Disease/Heart Murmur \*  Artificial Joint replacement\* \_\_\_\_\_\_\_  (year)  Allergic to x-ray dye  Allergic to Peanuts  Allergic to Shellfish    Allergic to any other medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any other special medical alerts? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **CURRENT MEDICATIONS** (Please list below any of the following)  **None**  **Over the Counter**  **Herbal Compounds**  **Prescription Medications**  **OVER** | | | |
| **FAMILY HISTORY**  Alcoholism  Diabetes  Suicide  Stroke  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | Cancer  Heart Disease  High Blood Pressure  Depression  Reviewed:\_\_\_ | |
| **SOCIAL HISTORY**  Do you drink alcohol? Beer Wine Other How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do/Did you smoke? Yes No How Long? \_\_\_\_\_\_\_\_\_  How many packs per day? \_\_\_\_\_\_ Year Quit? \_\_\_\_\_\_\_\_\_  Are you exposed to second-hand smoke? Yes No  Are you afraid of anyone close to you? Yes No  Has someone stopped you from seeking care? Yes No  Do you use marijuana? Yes No  If yes, what form (smoking, edible, dab pen, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you Vape? Yes No  Reviewed:\_\_\_ | | | |
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| |  |  |  | | --- | --- | --- | | DENTIST’S NAME | DENTIST’S TELEPHONE | | | **DENTAL HISTORY** | | | | Are your teeth sensitive to hot or cold? | | Yes  No | | Do you clench or grind your teeth? | | Yes  No | | Do you have popping or clicking in your jaw joints? | | Yes  No | | Have you ever had excessive bleeding following an extraction? | | Yes  No | | Have you ever become sick because of dental treatment? | | Yes  No | | Have you ever had an injury to your face or teeth? | | Yes  No | | Do you smoke or use any tobacco products? | | Yes  No | | Do you have any current health problems? | | Yes  No | | Have you been seen by a Physician in the past year? | | Yes  No | | Do you have a family doctor? (Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | | Yes  No | | May we share your dental information with your family doctor? | | Yes  No |   **Please explain Your dental complaint today.** | | | |
| **I understand that making a false statement of information is grounds for immediate termination from all Community HealthCare Connections programs. I certify that I have disclosed all forms of income for my family.** | | | |
| **Patient/Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_/\_\_\_/\_\_\_** | | | |
| Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Reviewed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  (For Nursing Clinic Patients Only) | | | |

Provider Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Provider Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Provider Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_