

**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[ ]  DepressionReviewed:\_\_\_ |
| **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 NoAre you afraid of anyone close to you? Yes NoHas someone stopped you from seeking care? Yes NoDo you use marijuana? Yes NoIf yes, what form (smoking, edible, dab pen, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you Vape? Yes NoReviewed:\_\_\_ |
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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: \_\_\_\_/\_\_\_\_/\_\_\_\_\_