FOUNTAIN CLINIC

Health History Form

Patient Name: ____________________________ Date of Birth: ____/____/____ Allergies: _________________

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:___

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:___

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:___

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:___

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: ____/____/_____