ROLLING HILLS CLINIC

# Health History

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

## Patient Information

First Name _____ Last Name _____ Middle _____

Gender ☐ Male ☐ Female ☐ Transgender

Date of Birth _____ SS# _____ Email _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widow

Address _____ City _____ State _____ Zip _____

Home Phone _____

Check this box if address and phone are the same for the entire family: ☐ Yes ☐ No

## 1. Today's Medical or Dental Problem:

## 2. Drugs & Medications

Are you taking any prescription or non-prescription medication? If you have more medications or cannot remember their names, please bring all your prescription bottles or a current list of your medications.

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

## 3. Past or Present Conditions

Please indicate any conditions that you are currently diagnosed with or that you have had in the past.

| Yes No | | Yes No | | Yes No | |
|---|---|---|---|---|---|
| ☐ ☐ | Chest Pain/Angina | ☐ ☐ | Leukemia | ☐ ☐ | Arthritis |
| ☐ ☐ | Fatigue/Frequently Tired | ☐ ☐ | High Blood Pressure | ☐ ☐ | Osteoporosis |
| ☐ ☐ | Difficulty Breathing | ☐ ☐ | Diabetes | ☐ ☐ | Stomach Troubles/Ulcers |
| ☐ ☐ | Joint Pain/ Swelling | ☐ ☐ | Urinary/Kidney Problems | ☐ ☐ | Glaucoma/Eye Problems |
| ☐ ☐ | Recent Weight Changes | ☐ ☐ | Stroke | ☐ ☐ | Rheumatic Fever |
| ☐ ☐ | Heart Murmur | ☐ ☐ | AIDS or HIV Infection | ☐ ☐ | Liver Disease |
| ☐ ☐ | Cardiac Pacemaker | ☐ ☐ | Sexually Transmitted Disease | ☐ ☐ | Mental/Nervous Disorder |
| ☐ ☐ | Swollen Ankles | ☐ ☐ | Hepatitis A B C _____ | ☐ ☐ | Depression |
| ☐ ☐ | Mitral Valve Prolapse | ☐ ☐ | Thyroid Problem | ☐ ☐ | Bipolar Disorder |
| ☐ ☐ | Joint Replacement or Implant | ☐ ☐ | High Cholesterol | ☐ ☐ | Schizophrenia |
| ☐ ☐ | Fainting | ☐ ☐ | Hay Fever/Allergies | ☐ ☐ | Developmentally Disabled |
| ☐ ☐ | Low Blood Pressure | ☐ ☐ | Heart Attack | ☐ ☐ | Anxiety |
| ☐ ☐ | Anemia | ☐ ☐ | Asthma | ☐ ☐ | Dementia |
| ☐ ☐ | Epilepsy/Seizures | ☐ ☐ | Heart Disease | ☐ ☐ | Autism |
| ☐ ☐ | Cancer | ☐ ☐ | Emphysema | ☐ ☐ | Special Needs |
| ☐ ☐ | Radiation Therapy | ☐ ☐ | Tuberculosis | ☐ ☐ | Other _____ |

## 4. Other Conditions or Special Needs

If you have a condition other than those listed above, please describe it below along with any information that will better help us understand its extent and history.

## 5. Pharmacy Which pharmacy do you prefer for prescriptions?

_____

Official Use Only

Chart Reviewed by:

## 6. Allergies
Are you allergic to or have you had any reactions to the following? Please check those that apply:

| Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | Sulfa Drugs | ☐ | ☐ | Any metals (e.g. nickel, mercury, etc.) | ☐ | ☐ | Sedatives |
| ☐ | ☐ | Barbiturates | ☐ | ☐ | Penicillin or other Antibiotics | ☐ | ☐ | Aspirin |
| ☐ | ☐ | Iodine | ☐ | ☐ | Local Anesthetics (e.g. Novocain) | ☐ | ☐ | **Latex** |

Please list other allergy-causing substances:
_____
_____
_____

## 7. Questions for Women

| | Yes | No |
|---|---|---|
| Are you pregnant or think you may be pregnant? | ☐ | ☐ |
| Are you taking oral contraceptive? | ☐ | ☐ |
| Are you nursing? | ☐ | ☐ |

Please indicate the dates
Last menstrual period _____
Last mammogram _____
Last pap _____

## 8. Family Medical History
Do any of the following conditions run in your family?
☐ None ☐ Diabetes ☐ Hypertension ☐ Heart Attack ☐ Stroke ☐ Cancer ☐ Other:_____

## 9. Immunizations
Please indicate the dates: Tetanus_____ Influenza_____ Pneumonia_____

## 10. Colonoscopy
Have you had a colonoscopy? ☐ Yes ☐ No If so, when? _____

## 11. Social History

| | Yes | No | |
|---|---|---|---|
| Have you ever used Phen-Fen or Redux? | ☐ | ☐ | |
| Do you have a history of recreational drug use? | ☐ | ☐ | If so, please list what kind:_____ |
| Do you smoke or chew tobacco? | ☐ | ☐ | If so, how much per day?_____ |
| Do you drink alcoholic beverages? | ☐ | ☐ | If so, how many drinks per day? _____ |
| Do you have a history of domestic violence? | ☐ | ☐ | Please explain _____ |

## 12. Premedication
In the past, have you had to take an antibiotic before dental treatment? ☐ Yes ☐ No ☐ Not Sure

## 13. Surgeries & Hospitalization
Have you been hospitalized for any surgical operation or serious illness within the last 5 years? Please list all surgeries and the year they were completed.

## 14. Current Medical Symptoms
Check all symptoms you are currently experiencing.

| | | | |
|---|---|---|---|
| ☐ Chest Pain/Angina | ☐ Cough | ☐ Stomach Pain | ☐ Rash |
| ☐ Difficulty Breathing | ☐ Fever | ☐ Diarrhea or Constipation | ☐ Depression/ SI |
| ☐ Fainting | ☐ Fatigue/Frequently Tired | ☐ Urinary Problems | ☐ Walker or Hearing Aids |
| ☐ Leg Swelling | ☐ Recent Weight Changes | ☐ Joint Pain/ Swelling | ☐ Other _____ |

## 15. Present Dental Conditions, Treatments, & Appliances

| | |
|---|---|
| ☐ Your gums bleed while flossing or brushing | ☐ Jaw clicking |
| ☐ Tooth sensitivity to hot or cold foods/liquids | ☐ Difficulty chewing |
| ☐ Tooth sensitivity to sweet or sour foods/liquids | ☐ Frequent headaches |
| ☐ Presence of sores or lumps in or near your mouth | ☐ Clenching your teeth |
| ☐ Pain in a specific location | ☐ Grinding your teeth |
| ☐ History of head, neck, or jaw injuries | ☐ Prolonged bleeding |
| ☐ Jaw pain (joint, ear, side of face) | ☐ Orthodontic treatment |
| ☐ Difficulty opening or closing | ☐ Use of full denture or partial denture |
| ☐ Biting the lips and cheeks frequently | ☐ Do you snore while sleeping? |

## 16. Authorization & Release
I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I ever have any changes in my personal information, health status, or my medication, I will inform the provider at the next appointment without failure. The undersigned client, patient, and/or responsible relative or guardian gives permission for the Rolling Hills Clinic to administer medical treatment, advice as necessary now or at any point during the period in which the client/patient is in our care.

Official Use Only Chart Reviewed by:

_____
Patient Signature (Parental/Legal Guardian) Patient Name (Print): _____