HOMETOWN
Health Center

Patient Medical /Dental History

Name: _____ DOB: _____ Date:_____

Preferred Method of Communication: Phone: ____ Mail: ____ Email: ____ Text: _____

Advanced Directive/Living Will: Yes_____ No _____

Occupation: Employer: _____Job Title:_____

Pharmacy Name: _____Phone Number: _____

Habits: Please circle all that apply.

Smoking:	Never	Former	Presently	# of packs/day
Alcohol:	None	Rarely	Occasionally	Socially
Drug Use:	None	Former	Presently	Type:
Caffeine:	None	1-2 cups/day	3-4 cups/day	More than 5 cups/day
Exercise:	None	Intermittently	Regularly	

Current Medication List: Please include any over-the-counter drugs, herbal supplements, vitamins, and birth control.

No Current Medications: _____

Medication	Dosage (mg)	Frequency	Prescribing Physician

Allergies: Please include food, drug, and environmental allergies.

No Known Allergies: _____

Allergy	Interaction	Allergy	Interaction

Previous Surgery History: Please list below.

No Past Surgical History: _____

Surgery	Year	Complications?

Relevant Family Medical History: Please check all that apply.

No Relevant Family History: _____

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts/ Uncles
Cancer									
Diabetes									
High Blood Pressure									
Heart Attack									
Heart Disease									
Blood Clots/DVT									
Stroke									
Mental Illness									
Drug/Alcohol Addiction									
Other Diseases Not Mentioned									
Living/Deceased									

Medical Problems: Please check all that apply.

No Medical Problems: _____

	Abdominal discomfort		Headaches		Sinus trouble
	Acid reflux		Heart attack		Skin rash/disorders
	ADD		Heart disease		Special diet
	ADHD		Heart murmur		Stroke
	AIDS/HIV		Hepatitis: specify A, B, C		Swollen feet/ankles
	Alcohol/drug abuse		High blood pressure		Swollen neck glands
	Anemia		High cholesterol		Thyroid problems
	Anxiety		Kidney disease		Tonsillitis
	Asthma		Kidney stones		Tuberculosis
	Arthritis, Rheumatism		Liver disease		Tumor or growths
	Artificial heart valves		Low blood pressure		Ulcers

					DENTAL HISTORY
	Artificial joints		Jaundice		Bad breath
	Autism		Joint replacement		Bleeding gums
	Back problems		Migraines		Blisters on lips/mouth
	Bleeding abnormally with extractions or surgery		Light-headedness		Burning sensation on tongue
	Blood disease		Lung disease		Chew on side of mouth
	Bronchitis		Mitral valve prolapsed		Cigarette, or other, smoking
	Cancer		Muscular Dystrophy		Clicking or popping jaw
	Chemical dependency		Nervous problems		Dry mouth
	Circulatory problems		Nausea		Fingernail biting
	Congenital heart lesions		Osteoporosis		Food collection in teeth
	Cortisone treatments		Pacemaker		Grinding teeth
	Cough, persistent or bloody		Psychiatric care		Loose teeth/broken fillings
	Cortisone treatments		Palpitations		Mouth pain/brushing
	Colitis		Pneumonia		Pain around ear
	Diabetes		Radiation treatment		Periodontal treatment
	Depression		Respiratory disease		Sensitive to hot/cold/sweets
	Emphysema		Recent surgery		Sensitive when biting
	Epilepsy		Rheumatic fever		Sores/growths in mouth
	Fainting or dizziness		Scarlet fever		Bubble/pimple on gum
	Glaucoma		Shortness of breath		

Health Maintenance Screenings: Please circle all that apply.

Colonoscopy	Yes No	Date:	Results:	Normal Abnormal
FIT/Stool Test	Yes No	Date:	Results:	Normal Abnormal
Mammogram	Yes No	Date:	Results:	Normal Abnormal
PAP Smear	Yes No	Date:	Results:	Normal Abnormal

Immunization History: Have you had:

Hepatitis B Series	Yes No	Date:	# of Doses if Known:	
TDaP/Tetanus	Yes No	Date:		
Pneumovax 23	Yes No	Date:		
Prevnar (Pneumo 13)	Yes No	Date:		
Flu	Yes No	Date:		

Women:

Are you pregnant? Yes _____ Due date: _____

No _____ Taking birth control pills _____

Are you breast feeding? Yes _____ No _____

Lifestyle:

Support Person #1: _____

Support Person #2: _____

Military Experience: Yes _____ No _____

Education: (Highest grade completed) _____

Hobbies/Activities: _____

Religion: _____

Have you recently traveled outside the area? Yes _____ No _____

If Yes, where: _____

Residence Information:

Housing Status: _____

Smoke Detectors: Yes _____ No _____

Firearms in the Home: Yes _____ No _____

Have you ever been a victim of abuse or domestic violence? Yes _____ No _____

Do you feel safe at home? Yes _____ No _____

Do you live alone? Yes _____ No _____

Please complete this health history and mail (in the postage paid envelope provided), drop off to one of our locations, or fax to us prior to your appointment.

If you cannot return this form prior to your appointment, you must arrive 15 minutes early, so you can complete the form.

Thank you for your cooperation and we look forward to having you as a patient!