COMMUNITY HEALTH ALLIANCE

ADULT HEALTH HISTORY

Patient Name:	DOB:	Date:
Main reason for today's visit:		
Where were you getting your MEDICAL care before? (Previous doctor/PCP):		
Where were you getting your DENTAL care before? (Dentist):		
In the past 2 weeks, have you been bothered by: Little interest or pleasure in doing things? ☐ Yes ☐ No Feeling down, depressed or hopeless? ☐ Yes ☐ No		

Review of symptoms: *Please mark the box (✓) and/or circle any persistent symptoms you have had in the past few months. Read through every section and check "no problems" if none of the symptoms apply to you. List other concerns above.*

General	**Respiratory**	**Gastrointestinal**	**Psychiatric**
__ Unexplained weight loss/gain __ Unexplained fatigue/weakness __ Fall asleep during day when sitting __ Fever, chills __ **No problems**	__ Altered breathing during sleep __ Cough producing blood __ Cough/wheeze __ Loud snoring __ short of breath with exertion __ **No problems**	__Heartburn/reflux/indigestion __ Blood or change in bowel movement __ Constipation __ **No problems**	__ Anxiety/stress __ Sleep problems __ Lack of concentration __ **No problems**
Skin	**Hematologic/Lymphatic**	**Eyes**	**Allergy/Immune**
__ New or change in a mole __ Rash/itching __ **No problems**	__ Swollen glands __ Easy bruising __**No problems**	__ Change in Vision __ Eye pain/redness __ **No problems**	__ Hay fever/allergies __ Frequent infections __ Lowered immune system __ **No problems**
Neurological	**Genitourinary**	**Ears/Nose/Throat**	**Women only**
__ Headache __ Memory loss __ Fainting/dizziness __ Numbness/tingling __ Unsteady gait __ Frequent falls __ **No problems**	__ Leaking urine __ Blood in urine __ Nighttime urination or increase frequency __ Discharge; penis or vagina __ Concern with sexual function __ **No problems**	__ Nosebleed __ Trouble swallowing __ Frequent sore throat __ Hoarseness __ Hearing loss __ Ringing in ears __ **No problems**	__ Pre-menstrual symptoms (bloating, cramps, irritability) __ Problem with menstrual periods __ Hot flashes __ Night sweats __ **No problems**
Cardiovascular	**Musculoskeletal**	**Endocrine**	**Breast**
__ Chest pain/discomfort __ Palpitations(fast or irregular heart beat) __ **No problems**	__ Neck pain __ Back pain __ Muscle/joint pain __ **No problems**	__ Heat or cold sensitivity __ **No problems**	__ Breast lump/pain __ Nipple discharge __ **No problems**

Please list (or show us your own printed record) all prescription and non-prescription medications, vitamins, home remedies, birth control pill, herbs, inhalers, etc.

☐ **TAKE NO MEDICATIONS** ☐ History of Blood thinning medications ☐ Current/Past Chemo Therapy

☐ History of steroid therapy ☐ History of aspirin therapy ☐ History of Osteoporosis medication

MEDICATIONS	DOSE(e.g. mg/pill)	HOW MANY TIMES PER DAY?	MEDICATIONS	DOSE(e.g. mg/pill)	HOW MANY TIMES PER DAY?

ALLEGIES OR INTOLERANCE TO MEDICATIONS:

Are you allergic to the following? DK (Don't know) ☐ **None**

Latex ☐ Yes ☐ No ☐ DK Metals ☐ Yes ☐ No ☐ DK Local anesthetic ☐ Yes ☐ No ☐ DK Iodine ☐ Yes ☐ No ☐ DK

Ibuprofen ☐ Yes ☐ No ☐ DK Sulfa/Sulfite ☐ Yes ☐ No ☐ DK Codeine ☐ Yes ☐ No ☐ DK Aspirin ☐ Yes ☐ No ☐ DK

Penicillin ☐ Yes ☐ No ☐ DK Other ANTIBIOTICS ☐ Yes ☐ No ☐ DK Other ☐_____

PERSONAL MEDICAL HISTORY: Do you have now (current) or have had (past) any of the following conditions?

CONDITION	CURRENT	PAST	CONDITION	CURRENT	PAST
Alcohol/Drug abuse			Heart Disease		
Anxiety			Heart Valve Replacement		
Arthritis			High Blood Pressure		
Asthma/COPD/Lung Disease			High Cholesterol		
Bleeding disorder			HIV/AIDS		
Cancer breast			Joint replacement/ when		
Cancer Colon			Kidney Disease/Failure (chronic)		
Cancer Cervical			Liver Disease/Cirrhosis/Hepatitis		
Cancer other type (See below)			Osteoporosis (See below)		
Congenital Methemoglobinemia			Radiation Therapy		
Depression			Rheumatic Fever		
Diabetes			Seizure/Epilepsy		
Do you have active/latent Tuberculosis/TB			Sleep Apnea		
Gastroesophageal Reflux (heartburn/GERD)			Stroke		
Glaucoma			Thyroid Disease		

Surgical History including Sterilization (Hysterectomy, Tubal Ligation, Vasectomy) : (List date and type of surgery)

_____

_____

_____

If you have Osteoporosis:

Are you taking or scheduled to begin taking either of the following medications, Alendronate (Fosamax) or Risedronate (Actonel) for osteoporosis? □ Yes □ No

If you have/had cancer:

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous Bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, Multiple Myeloma or Metastatic Cancer □ Yes □ No

FAMILY HISTORY-Indicate which relative has had the following disease (parents and siblings are most important)

Are you adopted and have no known family history? ☐ Yes ☐ No

Disease	Mother	Father	Siblings	Disease	Mother	Father	Siblings	Disease	Mother	Father	Siblings
No significant history known				Cancer Ovarian/ Cervical				High Blood Pressure/ Hypertension			
Alcohol abuse/Drug abuse				Cancer Prostate				High Cholesterol			
Alzheimer's/Dementia				Cancer other type				Hypothyroidism/Thyroid Disease			
Autoimmune Disease				Depression/Suicide/ Anxiety				Kidney Disease			
Cancer Breast				Diabetes				Osteoporosis			
Cancer Colon				Heart Disease				Stroke/CVA			

OTHER HEALTH ISSUES

Tobacco Use:
☐ Yes ☐ No ☐ Never Quit date_____
Approximately how many packs/day?____ # of years:_____
☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
☐ Electronic Cigarettes/ Vape ☐ Cigarettes

Alcohol Use:
Do you drink alcohol? ☐ Yes ☐ No # of drinks/week_____
Is your alcohol use a concern for you or others? ☐ Yes ☐ No

Safety: ☐ Decline to answer
Do you use a bike helmet? ☐ Yes ☐ No
Do you use seatbelts consistently? ☐ Yes ☐ No
Does your home have a working smoke detector? ☐ Yes ☐ No
If you have guns in your home, are they locked up? ☐ Yes ☐ No
Do you feel safe in your home? ☐ Yes ☐ No

Substance Use:
Do you use recreational drugs? ☐ Yes ☐ No
Have you ever used needles to inject drugs? ☐ Yes ☐ No

Sexual and Reproductive Health:
Are you currently using birth control? ☐ Yes ☐ No
Are you planning to have any/more children this year? ☐ Yes ☐ No
Would you like to discuss other birth control options? ☐ Yes ☐ No
Sexually active in past 3 months: ☐ Yes ☐ No # of partners_____ ☐ Declined
Who do you a have sex with ☐ Men ☐ Women ☐Both ☐ Other ☐ Declined
Have you had a sexually transmitted infection? ☐ Yes ☐ No
Have you ever had sex for money or traded for sex? ☐ Yes ☐ No

Women's Health History:
Total number of pregnancies:____ Number of deliveries: _____
Age periods started:_____ Age periods ended: _____ ☐ N/A
Are you pregnant? ☐ yes ☐ no Due date: _____

Social Support:
Spouse/Partner's name**:** _____ Number of children _____
Who lives with you? Ages if under 18 years of age:

Have you completed an Advance Directive for Health Care Living Will or POLST (Physician Orders for Life Sustaining Therapy?)
☐ Yes ☐ No If yes, was copy provided? ☐ Yes ☐ No

Education Level:
Highest grade completed:

DENTAL HISTORY			
Are your teeth sensitive to the cold, hot, sweets or pressure?	☐ Yes ☐ No ☐ DK	Do you have any clicking, popping or discomfort in the jaw?	☐ Yes ☐ No ☐ DK
Are you experiencing dental pain or discomfort?	☐ Yes ☐ No ☐ DK	Do you brux (clench) or grind your teeth?	☐ Yes ☐ No ☐ DK
Do you have any oral piercings/jewelry?	☐ Yes ☐ No ☐ DK	Oral habits (chewing fingernails, clenching, etc.)	☐ Yes ☐ No ☐ DK
Is your mouth dry?	☐ Yes ☐ No ☐ DK	Do you have any sores or ulcers in your mouth?	☐ Yes ☐ No ☐ DK
Have you had any periodontal (gum) treatments?	☐ Yes ☐ No ☐ DK	Have you ever had orthodontic (braces) treatment?	☐ Yes ☐ No ☐ DK
Do you bleach your teeth?	☐ Yes ☐ No ☐ DK	Do you wear a mouth guard when playing contact sports?	☐ Yes ☐ No ☐ DK
Have you had any problems associated with previous dental treatment	☐ Yes ☐ No ☐ DK	Have you ever had a serious injury to your head or mouth?	☐ Yes ☐ No ☐ DK
How many times do you brush daily?		How many times do you floss daily?	
How do you feel about your smile?			
Do you drink bottled water or filtered water? ☐ Yes ☐ No ☐ DK If yes, how often? Circle one: Daily Weekly Occasionally			
Date of your last dental exam:_____ ☐ Unknown What was done at the time:_____ ☐ Unknown		Date of last X-rays:_____ ☐ Unknown	
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No ☐ DK Name of physician or dentist making recommendation: ☐ Unknown			

_____ _____

Signature Date