CHCFC
Community Health Center of Franklin County

Medical & Dental Health History

Today's Date: _____

Name:_____ Date of Birth:_____

Date of last physical exam: _____ Date of last dental exam: _____

Previous Provider: _____ Previous Dentist: _____

City, State:_____ City, State:_____

Previous Pharmacy: _____

Allergies (including medication, food, and environmental) OR ☐No Known Allergies

_____

_____

Current Medications (including vitamins, supplements, and birth control) Please list name, dose, and frequency.

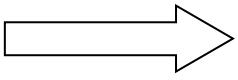
_____ _____

_____ _____

_____ _____

Please answer these questions as best you can by checking one of the following boxes, "Yes", "No", "NS" (Not Sure). Your answers are confidential and for our records only.

- Have you ever taken medications or received an IV to treat osteoporosis or bone issues (bisphosphonate drugs: Fosamax, Boniva, etc.)? ☐ Yes ☐ No ☐ NS
- Have you ever been hospitalized? ☐ Yes ☐ No ☐ NS
  - If yes, for what? _____
- Have you had surgery? ☐ Yes ☐ No ☐ NS
  - If yes, what surgery and when? _____
- When was your last tetanus shot? _____ Where? _____
- Have you had a colonoscopy? ☐ Yes ☐ No ☐ NS
  - If yes, when and where? _____
- Have you had a pap smear? ☐ Yes ☐ No ☐ NS
  - If yes, when and where? _____
- Have you ever had a mammogram? ☐ Yes ☐ No ☐ NS
  - If yes, when and where? _____
- Are you pregnant? ☐ Yes ☐ No ☐ NS
- Would you or your partner like to become pregnant in the next year? ☐ Yes ☐ No ☐ NS
- Are you currently breastfeeding? ☐ Yes ☐ No ☐ NS
- Do you or have you ever had exposure to hazardous material? ☐ Yes ☐ No ☐ NS
  - If yes, what material(s)? _____
- Do you use tobacco products or vape? ☐ Yes ☐ No ☐ NS



- If yes, what type and how often? _____
- Do you exercise? ☐ Yes ☐ No ☐ NS
  - If yes, what kind and how often? _____
- Are you on any special diet? ☐ Yes ☐ No ☐ NS
  - If yes, type? _____
- Do you see a specialist for a medical condition? ☐ Yes ☐ No ☐ NS
  - If yes, name and specialty? _____

Please check the boxes below that apply to your health history.

Heart/Blood Problems	Stomach/Intestine Problems	Mouth/Teeth Problems
☐ **NONE** ☐ Angina (chest pain) ☐ Congenital defect ☐ Endocarditis ☐ Anemia ☐ Heart attack_____(date) ☐ Heart surgery _____(date) ☐ High blood pressure ☐ Mitral valve prolapse ☐ Murmur ☐ Pacemaker ☐ Stroke: _____(date) ☐ Other:_____	☐ **NONE** ☐ Crohn's disease ☐ GERD (heartburn / acid reflux) ☐ Hepatitis: A B C ☐ Irritable bowel syndrome ☐ Jaundice ☐ Stomach ulcers ☐ Ulcerative colitis ☐ Other:_____ _____	☐ **NONE** ☐ Bleeding gums ☐ Clenching/grinding ☐ Difficulty chewing ☐ Difficulty swallowing ☐ Jaw pain ☐ Pain/Swelling ☐ Sensitivity ☐ Sores in mouth ☐ Other:_____ _____
Bone/Muscle Problems	**Endocrine Problems**	**Lung Problems**
☐ **NONE** ☐ Chronic pain ☐ Joint replacement: (which joint/when) _____ ☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ TMJ Disorder ☐ Other:_____ _____	☐ **NONE** ☐ Diabetes: TYPE 1 TYPE 2 ☐ Overactive Thyroid (hyperthyroidism) ☐ Underactive Thyroid (hypothyroidism) ☐ Other:_____ _____	☐ **NONE** ☐ Asthma ☐ COPD ☐ Cough with blood ☐ Persistent cough ☐ Shortness of breath ☐ Tuberculosis ☐ Other:_____ _____
Sexual Health History *The following questions are personal but are important in helping us give you the best care.* ☐ I have been sexually active in the past ☐ I am currently sexually active ☐ I have had more than one partner in the past year ☐ I have been forced or pressured into sexual activity	**Mental Health History** ☐ **NONE** ☐ Anxiety ☐ Bipolar disorder ☐ Depression ☐ PTSD ☐ Other:_____ _____	**Other** ☐ Glaucoma ☐ Kidney problems ☐ HIV/AIDS ☐ History of seizure ☐ Cancer (type): _____ _____ ☐ Any other condition or problem(s): _____ _____

Signature: _____ Date:_____

Reviewed By (Provider Signature):_____