CHCFC
Community Health Center of Franklin County

NEW PATIENT HEALTH HISTORY

NAME:_____ **DATE OF BIRTH:**_____

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

Provider: _____ Dentist: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

MEDICATIONS (including over-the-counter medications, vitamins, and supplements):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES (including medication, food, and environmental):

☐ **NO KNOWN ALLERGIES** ☐ Aspirin ☐ Barbiturates ☐ Iodine ☐ Latex/rubber

☐ Local Anesthetics ☐ Penicillin ☐ Metals ☐ Sedatives ☐ Sulfa

☐ Other:_____

_____

Do you take, or have ever taken, bisphosphonate drugs (e.g. Fosamax, Actonel, Boniva)? **YES** **NO**

Have you ever been **hospitalized**? ..... **YES** **NO**

If yes, what for? _____

Have you had any **surgeries**? ..... **YES** **NO**

If yes, what for? _____

When was your last **colonoscopy**? _____

When was your last **tetanus** shot? _____

* WOMEN ONLY *

Are you pregnant or do you think you might be pregnant? ..... **YES** **NO**

Are you currently breastfeeding? ..... **YES** **NO**

When was your last Pap smear? _____ Abnormal Pap smears? **YES** **NO**

When was your last mammogram? _____ Abnormal mammograms? **YES** **NO**

Reviewed by provider (initials): _____

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MEDICAL HISTORY

HEART / BLOOD VESSELS

☐ **NONE**
☐ Angina (chest pain)
☐ Congenital defect
☐ Endocarditis
☐ Heart attack_____(date)
☐ Heart surgery _____(date)
☐ High blood pressure
☐ Mitral valve prolapse
☐ Murmur
☐ Pacemaker
☐ Stroke: _____(date)
☐ Other:_____

LUNGS

☐ **NONE**
☐ Asthma
☐ COPD
☐ Cough with blood
☐ Persistent cough
☐ Shortness of breath
☐ Tuberculosis
☐ Other:_____

MOUTH / TEETH

☐ **NONE**
☐ Bleeding gums
☐ Clenching/grinding
☐ Difficulty chewing
☐ Difficulty swallowing
☐ Jaw pain
☐ Pain/Swelling
☐ Sensitivity
☐ Sores in mouth
☐ Other:_____

STOMACH / INTESTINES

☐ **NONE**
☐ Crohn's disease
☐ GERD (heartburn / acid reflux)
☐ Hepatitis: A B C
☐ Irritable bowel syndrome
☐ Jaundice
☐ Stomach ulcers
☐ Ulcerative colitis
☐ Other:_____

ENDOCRINE

☐ **NONE**
☐ Diabetes: TYPE 1 TYPE 2
☐ Overactive (hyperthyroidism)
☐ Underactive (hypothyroidism)
☐ Other:_____

SEXUAL

☐ **NONE**
☐ AIDS/ HIV
☐ Herpes
☐ HPV
☐ Other:_____

BONES/MUSCLES/JOINTS

☐ **NONE**
☐ Chronic pain
☐ Joint replacement:
(which joint/when) _____
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ TMJ Disorder
☐ Other:_____

BRAIN/EMOTIONS/NERVES

☐ **NONE**
☐ Anxiety
☐ Bipolar disorder
☐ Depression
☐ PTSD
☐ Other:_____

OTHER

☐ Anemia
☐ Glaucoma
☐ Kidney problems
☐ Other Condition(s): _____

☐ Cancer (type): _____

SOCIAL HISTORY

Hazardous material exposure? **YES** **NO** Specify: _____
Do you use tobacco products? **YES** **NO** Type: _____ How much/How long? _____
How often do you drink alcohol? _____ # of drinks per day _____ Type_____
Have you ever used street drugs? **YES** **NO** Type: _____
Do you drink caffeinated beverages? **YES** **NO** Type: _____
Do you drink sweetened beverages? **YES** **NO** Type: _____
Are you on any special diet? **YES** **NO** Type: _____
Do you exercise? **YES** **NO** What kind/How often?_____
What is the highest level of education you have attained? _____

SIGNATURE:_____ **DATE:**_____

Reviewed by provider (initials): _____