CHC Community Health Center OF SNOHOMISH COUNTY

Health History – Adult Patient

Information is for our records only and will be kept confidential

Patient ID Label

NAME: _____/_____/_____ TODAY'S DATE: _____
Last First Middle

DATE OF BIRTH: _____ GENDER: ☐ Male ☐ Female

CLOSEST RELATIVE OR CONTACT PERSON: _____ PHONE: _____

If person completing this form is not the patient, what is your relationship to patient? _____

NAME OF PHYSICIAN: _____ DATE OF LAST PHYSICAL EXAM: _____

PHYSICIAN'S ADDRESS: _____ PHONE: _____

Please Check ☑	YES or NO:
☐ Yes ☐ No	Are you in good health?
☐ Yes ☐ No	Has there been any change in your general health within the past year? If yes, what? _____
☐ Yes ☐ No	Are you under the care of a physician? If yes, what is the condition being treated? _____
☐ Yes ☐ No	Have you had a serious illness or operation? If yes, what was the illness or operation? _____
☐ Yes ☐ No	Have you been hospitalized in the past 5 years? If yes, why? _____
☐ Yes ☐ No	Cardiovascular disease (heart trouble, heart attack, coronary occlusion, coronary insufficiency)
☐ Yes ☐ No	Damaged heart valves, artificial heart values, or heart murmur?
☐ Yes ☐ No	Have you ever required a blood transfusion? If yes, explain why:_____
☐ Yes ☐ No	Do you have any blood disorder such as anemia?
☐ Yes ☐ No	Have you had surgery, radiation or drug treatment for a tumor, growth or other condition?
☐ Yes ☐ No	Have you had any serious trouble associated with any previous dental treatment?
☐ Yes ☐ No	Are you currently or have you ever been in a drug addiction program?
☐ Yes ☐ No	Are you currently using any recreational drugs? If yes, please list:_____
☐ Yes ☐ No	Are you on now or have you even been on medication for osteoporosis (bisphosphonates such as Fosamax)?
☐ Yes ☐ No	Do you have pain in chest upon exertion?
☐ Yes ☐ No	Do you have a cardiac pacemaker?
☐ Yes ☐ No	Have you ever been diagnosed with cancer?
☐ Yes ☐ No	Are you employed in any situation that exposes you regularly to x-rays or other ionizing radiation?
☐ Yes ☐ No	Do you smoke?
☐ Yes ☐ No	Do you have any disease, condition, or problem not listed above that you think I should know about? If yes, explain: _____

Do you have now or have you ever had any of the following diseases or problems: Check ☑	YES or NO:
☐ Yes ☐ No	Immune compromising or autoimmune illness such as HIV, AIDS or Lupus
☐ Yes ☐ No	Diabetes If yes, is it controlled? _____ What type do you have? _____
☐ Yes ☐ No	Sinus trouble
☐ Yes ☐ No	Asthma
☐ Yes ☐ No	Arthritis If yes, what type_____
☐ Yes ☐ No	Stomach ulcers
☐ Yes ☐ No	Kidney trouble
☐ Yes ☐ No	Tuberculosis

* * * * * *Please complete other side* * * * * *

DEN Form 104D (Rev 04/22)

☐ Yes ☐ No Venereal disease If yes, what disease: _____

☐ Yes ☐ No Abnormal bleeding associated with previous extractions, surgery, or trauma

☐ Yes ☐ No Bruise easily

☐ Yes ☐ No High blood pressure

☐ Yes ☐ No Stroke

☐ Yes ☐ No Congenital heart lesions

☐ Yes ☐ No Liver disease

☐ Yes ☐ No Hepatitis If yes, what type? _____

☐ Yes ☐ No Fainting spells, seizures or epilepsy

Are you allergic to or have you reacted adversely to any of the following? Check ☑ YES or NO

☐ Yes ☐ No Local anesthetics. If yes, what happened? _____

☐ Yes ☐ No Penicillin. If yes, what happened? _____

☐ Yes ☐ No Other Antibiotic _____. If yes, what happened? _____

☐ Yes ☐ No Aspirin. If yes, what happened? _____

☐ Yes ☐ No Codeine or other narcotics. If yes, what happened? _____

☐ Yes ☐ No Barbiturates, sedatives, or sleeping pills. If yes, what happened? _____

☐ Yes ☐ No Latex or natural rubber. If yes, what happened? _____

☐ Yes ☐ No Other _____. If yes, what happened? _____

Please list all current prescribed and over the counter medications:

Medicine Name (Please use additional paper if needed)	**Dose**	**How often?**

WOMEN

☐ Yes ☐ No Are you pregnant or think you might be pregnant?
If yes, what is your due date? _____

☐ Yes ☐ No Are you nursing?

☐ Yes ☐ No Is this your first child?

I certify that I have read and understand the above and acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any CHC employee responsible for any errors/omissions that I may have made in completing this form.

Patient/Parent/Guardian Signature	Dentist/Hygienist Signature	Date
Printed Interpreter Name		
Interpreter Signature		