HOPE CLINIC OF ROSS COUNTY

Place printed label here

Physical Health History

Name_____ Date of Birth_____
Birth Gender: Male _____ Female _____

Primary Care Provider other than Hope Clinic_____
Date you last saw a Primary Care Provider _____ Date of your last physical exam _____

Are you pregnant? ___Yes ____No Are you breastfeeding? ___Yes ____No Date of last period: _____

Medication or other allergies: _____Yes _____No List: _____
_____
_____

MEDICAL PATIENTS *COMPLETE THE INFORMATION BELOW*
DENTAL PATIENTS *COMPLETE THE INFORMATION ON BACK*

MEDICAL HISTORY: Have there been any changes since your last visit?
YES ____ NO ____ **If 'NO' initial here and skip to the signature line_____**
If there have been changes, or you are uncertain of any changes, **please circle below** where applicable. ***NEW PATIENTS*** PLEASE CIRCLE BELOW WHERE APPLICABLE:

Alcohol/ Drug Abuse	Abnormal Bleeding	Anemia	Aneurysm	Anxiety	Asthma	Birth Defects	Blood Disease
Bloody Stools	Bronchitis	Cancer	Cataracts	Colitis	Depression	Diabetes	Emphysema
Fainting	Gallbladder Disease	Genital Herpes	Genital Warts	Glaucoma	Gonorrhea/Syphilis	Heart Attack	Heart Murmur
Heart Problems	Heart Valve Replacement	Hemorrhoids	Hepatitis A, B or C	High Blood Pressure	HIV/AIDS	Jaundice	Joint Replacement
Kidney Stones/Disease	Liver Disease	Low Blood Pressure	Lupus	Macular Degeneration	Migraines	Osteoarthritis	Pneumonia
Prosthetic Joint	Psychiatric Problem	Recent Weight Loss	Rheumatic Fever	Rheumatoid Arthritis	Seizures/Epilepsy	Smoking	Stroke
Thyroid/Goiter	Tuberculosis	Ulcers	Urinary Infection	Other:			

Past surgeries/hospitalizations: _____

Signature: _____ Date _____

DENTAL PATIENTS ONLY

Have you ever been hospitalized or had a major operation? _____Yes _____No
Have you ever had a serious head or neck injury? _____Yes _____No
Do you take, or have you taken, Phen-Fen or Redux? _____Yes _____No
Have you ever taken Fosamax, Boniva, Actonel or other medications containing bisphosphonates?
_____Yes _____No
Are you on a special diet? _____Yes _____No Do you use a controlled substance? ____Yes ____No

PLEASE MARK ANY OF THE BELOW THAT APPLY:

AIDS/HIV Positive	Alzheimer's Disease	Anaphylaxis	Anemia	Angina	Arthritis/ Gout	Artificial Heart Valve
Artificial Joint	Asthma	Blood Disease	Blood Transfusion	Breathing Problems	Bruises Easily	Cancer
Chemotherapy	Chest Pains	Cold Sores/Fever Blisters	Congenital Heart Disorder	Convulsions	Cortisone Medicine	Diabetes
Drug Addiction	Easily Winded	Emphysema	Epilepsy or Seizures	Excessive Bleeding	Excessive Thirst	Fainting Spells/ Dizziness
Frequent Cough	Frequent Diarrhea	Frequent Headaches	Genital Herpes	Glaucoma	Hay Fever	Heart Attack/ Failure
Heart Murmur	Heart Pacemaker	Heart Trouble/Disease	Hemophilia	Hepatitis A	Hepatitis B or C	Herpes
High Blood Pressure	High Cholesterol	Hives or Rash	Hypoglycemia	Irregular Heartbeat	Kidney Problems	Leukemia
Liver Disease	Low Blood Pressure	Lung Disease	Mitral Valve Prolapse	Osteoporosis	Pain in Jaw Joints	Parathyroid Disease
Psychiatric Care	Radiation Treatments	Recent Weight Loss	Renal Dialysis	Rheumatic Fever	Rheumatis	Scarlet Fever
Shingles	Sickle Cell Disease	Sinus Trouble	Spina Bifida	Stomach/ Intestinal Disease	Stroke	Swelling of Limbs
Thyroid Disease	Tonsillitis	Tuberculosis	Tumors or Growths	Ulcers	Venereal Disease	Yellow Jaundice

Have you ever had any serious illness not listed above: _____

_____

Any comments? _____

_____

Signature: _____ Date _____