Ho'ola Lahui Hawai'i - Kaua'i Community Health Center
Medical & Dental and Health History Form

Print Form

Patient Name: | Date of Birth:

Medical Physician's Name: | Date of last visit:

HEALTH HISTORY (Please check [x] YES or NO for the following)

AIDS / HIV	YES	NO	Emphysema	YES	NO	Scarlet Fever	YES	NO
Anemia	YES	NO	Epilepsy	YES	NO	Shortness of Breath	YES	NO
Arthritis/Rheumatism	YES	NO	Fainting or Dizziness	YES	NO	Sinus Trouble	YES	NO
Artificial Heart Valves	YES	NO	Glaucoma	YES	NO	Skin Rash	YES	NO
Artificial Joints	YES	NO	Gout	YES	NO	Stroke	YES	NO
Asthma	YES	NO	Headaches	YES	NO	Swelling of Feet or Ankles	YES	NO
Attention Deficit Disorder	YES	NO	Heart Murmur	YES	NO	Swollen Neck Glands	YES	NO
Back Problems	YES	NO	Heart Problems	YES	NO	Thyroid Problems	YES	NO
Bleeding abnormally w/ Extractions or surgery	YES	NO	Hepatitis Type ____	YES	NO	Tonsillitis	YES	NO
			Herpes	YES	NO	Tuberculosis	YES	NO
Blood disease	YES	NO	Jaundice	YES	NO	Tumor/growth	YES	NO
Cancer	YES	NO	Jaw Pain	YES	NO	Ulcer	YES	NO
Chemical Dependency	YES	NO	Kidney Disease	YES	NO	Weight Loss	YES	NO
Chemotherapy	YES	NO	Liver Disease	YES	NO	Sexually Transmitted Diseases (Syphilis, Gonorrhea, etc.)	YES	NO
Circulatory Problems	YES	NO	High/Low Blood Pressure	YES	NO			
Congenital Heart Lesions	YES	NO	Mitral Valve Prolapse	YES	NO			
Contact Lenses	YES	NO	Nervous Problems	YES	NO			
Cortisone Treatments	YES	NO	Osteoporosis	YES	NO			
Cough, persistent/bloody	YES	NO	Pacemaker	YES	NO			
Diabetes	YES	NO	Psychiatric Care	YES	NO			
Diet pill by prescription ("fen-phen, Fastin, redux"	YES	NO	Radiation Treatment	YES	NO			
			Respiratory Disease	YES	NO			
Do you use tobacco/street or recreation drugs?	YES	NO	Rheumatic Fever	YES	NO			
Are you a former user of any form of tobacco?	YES	NO						

List any other medical condition not listed:

Do you worry more than you used to? (Yes or No)

Do you lack energy to do things you enjoy? (Yes or No)

WOMEN:

Are you nursing? YES NO

Are you pregnant? YES NO

List Any Medications Currently Taking and Why:
(OR) Please write NONE if you are not taking any

CHECK ALL ALLERGIES:

☐ None ☐ Aspirin ☐ Barbiturates (Sleeping Pills) ☐ Codeine

☐ Iodine ☐ Latex ☐ Local Anesthetic ☐ Penicillin ☐ Sulfa

☐ Other (Please List)

Reason for today's visit:

Former Doctor:

THIS SECTION - DENTAL PATIENTS ONLY - Check if any of the following apply to you:

- ◯ Bad Breath
- ◯ Bleeding Gums
- ◯ Blisters on lips or mouth
- ◯ Burning Sensation on tongue
- ◯ Chew on one side of mouth
- ◯ Clicking or Popping Jaw
- ◯ Dry Mouth
- ◯ Fingernail Biting
- ◯ Food Collection between teeth
- ◯ Foreign Objects
- ◯ Grinding Teeth
- ◯ Loose Teeth or broken fillings
- ◯ Mouth breathing
- ◯ Mouth Pain when brushing
- ◯ Orthodontic Treatment
- ◯ Pain around ear or jaw
- ◯ Periodontal Treatment
- ◯ Sensitivity to cold
- ◯ Sensitivity to heat
- ◯ Sensitivity to sweets
- ◯ Sensitivity when biting
- ◯ Sores or growth in mouth

Date of last dental visit | How often do you brush

Date of last x-rays | How often do you floss

Patient Signature: | Date:

Updated: 02-08-16