• Monsey Medical and Dental Center • Dental Care on Wheels • The Ben Gilman Spring Valley Medical & Dental Clinic

Health History Form

Patient's Name:_____ DOB:___/___/___ Chart #_____

Name of Primary Physician:_____ Phone #_____

DATE OF LAST VISIT TO A PHYSICIAN:_____REASON FOR VISIT: _____

CURRENT HEALTH STATUS: [ ] GOOD [ ] FAIR [ ] POOR

HAVE YOU HAD ANY SERIOUS HEALTH PROBLEMS IN THE LAST FIVE YEARS? [ ] Yes [ ] No

If yes, please explain: _____

ARE YOU CURRENTLY TAKING ANY FORM OF MEDICATION? [ ] Yes [ ] No

If yes, please list: _____

Are you Allergic to any Medications? [ ] Yes [ ] No If Yes, please specify: _____ _____

Are you Allergic to any Foods? [ ] Yes [ ] No IfYes, please specify: _____

Are you Allergic to any substance or environmental material? [ ] Yes [ ] No If yes, please specify: _____

Date of last mammogram? ___/____/____ Facility_____ Not applicable _____

Date of last papsmear? ____/____/____ Facility _____ Not applicable _____

Have you had or received treatment for any of the following?			**If yes, please describe:**
Heart Problems/ Rheumatic Fever/Heart Murmur	**[ ] Yes**	**[ ] No**	_____
Stroke	**[ ] Yes**	**[ ] No**	_____
Hepatitis	**[ ] Yes**	**[ ] No**	_____
High Blood Pressure	**[ ] Yes**	**[ ] No**	_____
Tuberculosis	**[ ] Yes**	**[ ] No**	_____
Asthma	**[ ] Yes**	**[ ] No**	_____
Diabetes	**[ ] Yes**	**[ ] No**	_____
Cancer (Tumor)	**[ ] Yes**	**[ ] No**	_____
Pain	**[ ] Yes**	**[ ] No**	_____
Headache	**[ ] Yes**	**[ ] No**	_____
Anemia	**[ ] Yes**	**[ ] No**	_____
Kidney Disease	**[ ] Yes**	**[ ] No**	_____
Thyroid Disease	**[ ] Yes**	**[ ] No**	_____
Bleeding Problems	**[ ] Yes**	**[ ] No**	_____
HIV+/AIDS	**[ ] Yes**	**[ ] No**	_____
Sexually Transmitted Diseases	**[ ] Yes**	**[ ] No**	_____
Fainting/Seizure/Epilepsy	**[ ] Yes**	**[ ] No**	_____

Have you ever had a major operation? [ ] Yes [ ] No

If yes, please describe: _____

Are you pregnant? [ ] Yes [ ] No [ ] Not Applicable

Have you been treated by a psychiatrist, psychologist, or social worker/counselor? [ ] Yes [ ] No

If yes, please describe: _____

Do you have a history of using drugs/alcohol? [ ] Yes [ ] No **Do you have a history of serious emotional problems? [ ] Yes [ ] No**

Have you been a victim of abuse? [ ] Yes [ ] No **Do you feel overwhelmed by life often? [ ] Yes [ ] No**

Do you feel hopeless and joyless about life? [ ] Yes [ ] No

Are you aware of any other medical problem? [ ] Yes [ ] No

If yes, please describe: _____

_____ _____ _____

PATIENT/GUARDIAN SIGNATURE **PRINT** **DATE**