Patient Name: _____

Date of Birth: _____

Name:_____ Date of Birth:_____

Today's Date: _____

What is the reason for your medical appointment today?: _____

When was your last Medical visit? _____ Who is your Primary Medical Provider? _____

What is the reason for your dental appointment today? _____

When was your last Dental visit? _____ Who is your Primary Dental Provider? _____

Women only- Are you pregnant? _____ Yes _____ No Due Date: _____ Nursing? ___Yes ____No

ALLERGIES: Please include medications such as Sulfa, Penicillin, Aspirin, Codeine, other drugs/medications, and Latex, Metals, dental materials, or food	**REACTION (hives, rash, etc.)**

MEDICATIONS, VITAMINS, HERBAL SUPPLEMENTS CURRENTLY TAKING:	**DOSE:**	**HOW OFTEN:**

Patient Name: _____

Date of Birth: _____

What Pharmacy do you use? _____ Street: _____

City: _____ State: _____

PAST HISTORY: Have you ever had or do you now have any of the following:

Check each item	**Yes**	**No**	**Check each item**	**Yes**	**No**
Alcohol use - Do you have a desire to quit? Yes No			(Hypotension) Low Blood Pressure		
Anemia or other blood disease			Meningitis		
Anorexia			Menstrual difficulties		
Appendicitis, acute or chronic			Mononucleosis		
Arthritis			Nervous or mental disease		
Artificial Heart Valves			Pacemaker		
Asthma			Pneumonia		
Autism			Poliomyelitis		
Back problems			Pregnancies		
Binge eating			Psychiatric Care		
Bleeding Abnormalities			Recreational Drugs:(i.e. Meth, Cocaine, Ecstasy) - Do you have a desire to quit? Yes No		
Bronchitis			Respiratory Disease		
Cancer : Please list Type: _____			Rheumatic fever		
Chemotherapy or Radiation Treatments			Hernia		
Cardiovascular disease			Sexually transmitted diseases		
Chickenpox			Shortness of Breath		
Depression/Anxiety			Sinus disease		
Diabetes			Skin disease		
Ear infections, disease, mastoid, etc.			Smoker - Do you have a desire to quit? Yes No		
Emphysema/COPD			Stroke		
Epilepsy or convulsive disorder			Swollen Neck Glands		
Gallbladder disease			Thyroid trouble		
Glaucoma			Tonsillitis		
Hay fever			Tuberculosis		
Headache			Tumor or growth on head or neck		
Hearing Loss			Ulcer, stomach or duodenal		

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Hepatitis			Vertigo (dizziness) or fainting spells		
HIV infection			Vomiting or losing weight		
Hypertension (High Blood Pressure)			Whooping cough		
Jaw Pain			Liver disease		
Jaundice			Kidney disease		
Injuries (serious)					

If yes, please explain:

_____

Have you had any surgeries or hospitalizations? (please place date or approximate date on line)

Appendectomy _____ Tonsillectomy _____ Adenoidectomy_____

Hysterectomy_____ Cholecystectomy (gallbladder removal) _____ Caesarean Section _____

Other (please explain): _____

Please indicate when you last had any of the following diagnostic tests and/or screening services and when and where those were completed:

Test/Screening/Vaccine	**Date Completed:**	**Place of Service:**	**May we obtain these records?**
Mammogram			Yes No
Colonoscopy			Yes No
Colon Cancer Stool Test			Yes No
Cervical Cancer Screening/ PAP Smear			Yes No
Bone Density Test (DEXA Scan)			Yes No
HIV Screening			Yes No
Hepatitis C Screening			Yes No
Tetanus Vaccine			Yes No
Pneumonia Vaccine			Yes No
COVID Vaccine			Yes No

Patient Name: _____

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Flu Vaccine			Yes No
Eye Exam			Yes No

If you consent to Eagle View Community Health System obtaining your records to keep your medical record up to date, please sign the attached consent form.

SOCIAL HISTORY:

Living Status: ____ Alone ____ With Parents ____ With Spouse ____ Assisted Living or Nursing Home _____ Other

Education: ___ Elementary ___ Junior High ___ High School ____ College ____ Post Grad ___ Doctorate

Caffeine: ___ Never ___ Past ___Current Type: ___ Coffee ___ Tea ___ Soda ___ Energy Drinks ____ How many cups daily? _____

Exercise: ____ None ___ Aerobics ___ Walking ___ Weightlifting ___ Other _____Days/Weekly

Do you require communication needs: ____ Hearing _____ Vision _____ Reading _____ Other (please list): _____

Other: Do you currently have:

A Living Will?	Yes / No
Medical Power of Attorney?	Yes / No
Would you like more information regarding a Living will and/or Medical Power of Attorney?	Yes / No

FAMILY HISTORY: Do any of your blood relatives have a history of any of the following? If so, please circle.

	Family Relationship		**Family Relationship**
Cancer: Yes/ No Type_____		Kidney Disease	

Patient Name: _____

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Heart Disease		Diabetes	
High Blood Pressure		Nervous or Mental disease	
Liver Disease		Asthma or Hay Fever (allergies)	
Stroke		Convulsions	
Tuberculosis		Stomach Disease	
Lung Disease		Alcohol or Drug Use	

DENTAL HISTORY:

Are you experiencing pain/discomfort today? YES NO	Do your gums bleed when brushing teeth or flossing? YES NO
Have you ever been diagnosed with any health conditions that require a pre-medication antibiotic before dental treatment? YES NO Please Explain: _____	How many times per day do you floss? ____ Brush? _____ Type of Bristles: ___Hard __Medium __Soft
Are you unhappy with the appearance of his/her teeth? YES NO	Do you have regular dental checkups? YES NO - Date of Last Exam: _____ - Date of Last Xray's: _____
Do you suffer from pain in mouth, face, neck, throat or jaw (TMJ)? YES NO	Are you taking fluoride supplements? YES NO
Do you have fear which has prevented patient from seeking dental care? YES NO	Does the water you drink contain fluoride? YES NO UNKNOWN
Are you allergic to any metals or dental materials? YES NO	When was the last date of fluoride application? _____
Have you ever had any of the following dental treatments? (please circle) Fillings Crowns Braces Implants Root Canal Oral Surgery Bridges Implants	

Patient Name: _____

Date of Birth: _____

AGREEMENT & CONSENT

The undersigned may voluntarily seek medical, dental, and/or surgical treatment or diagnosis from the health care and dental providers at EVCHS. I hereby authorize and give consent for dental radiographs, study models, photographs, or any other diagnostic aids deemed appropriate for the diagnosis of the patient's dental needs, as well as laboratory tests, X-rays, EKGs, and other routine medical treatment and diagnostic procedures as may be necessary at any given time. The undersigned consents to and authorizes all treatments, the performance of minor operations and the administration of local anesthetics, and any or all other technical procedures which in the judgement of the health care provider may be considered necessary or advisable for diagnosis and/or treatment. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services rendered. I authorize release of any information to my insurance company related to my medical/dental claims.

My signature as follows verifies that I am the patient or the parent/guardian/legal custodian of the patient as named above.

Signature of Patient or parent/guardian/Legal Custodian: _____

Printed Name of Patient or parent/guardian/Legal Custodian: _____

Relationship to patient: _____ Date: _____