Noble Community Clinics

Adult Health History: (13 years and over)

Patient Name:_____**DOB:**_____

Are you under the care of a physician? Yes/No
Please list the name and phone number of the physician:

Name:_____ Phone: _____

Has there been any change in your general health within the past year? Yes/No

If yes, please describe: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years? Yes/No

If yes, please describe: _____

Are you taking or have you recently taken any prescriptions or over the counter medication? Yes/No

If yes, please list all: _____

Do you have any allergies to drugs, foods, medications, latex, local anesthetic, peroxide, mint? Yes/No

If yes, please list all: _____

Joint Replacement: Have you had any total joint (hip, knee, elbow, finger) replacement(s)? Yes/No

If yes, please list date of replacements: _____
Have you had any complications? _____

Do you have osteoporosis? Yes/No
If yes, are you taking an antiresorptive agent? Yes/No

Do you use controlled substances (drugs)? Yes/No

Do you use tobacco (smoking, snuff, chew, bidis)? Yes/No
If so, how interested are you in stopping? (Circle one) Very / Somewhat / Not Interested

Women Only:
Are you pregnant? Yes/No If yes, how many weeks? ___
Are you nursing? Yes/No
Are you taking any form of birth control or hormonal replacement? Yes/No

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Adult Health History: (13 years and over)

Please indicate if you have or have had in the past any of the following diseases or problems:

Artificial (prosthetic) heart valve? Yes/No
Previous infective endocarditis? Yes/No
Congenital heart disease (CHD)? Yes/No
Cardiovascular Disease? Yes/No
Angina (chest pain)? Yes/No
Arteriosclerosis (hardening of arteries)? Yes/No
Asthma or COPD? Yes/No
Congestive heart failure? Yes/No
Heart Attack? Yes/No
Heart Murmur? Yes/No
Low or high blood pressure? Yes/No
Other congenital heart defects? Yes/No
Autoimmune Disease? Yes/No
Rheumatoid Arthritis? Yes/No
Systemic lupus erythematosus? Yes/No
Sinus Trouble? Yes/No
Tuberculosis? Yes/No
Cancer/Chemotherapy/Radiation? Yes/No

Diabetes Type I or II? Yes/No If yes, which type: _____
Eating Disorder? Yes/No
Gastrointestinal disease, G.E. reflux/persistent heartburn, ulcers? Yes/No

Thyroid Problems? Yes/No
Stroke? Yes/No
Glaucoma? Yes/No
Hepatitis, jaundice or liver disease? Yes/No
Epilepsy? Yes/No
Fainting spells or seizures? Yes/No
Neurological Disorders? Yes/No
Mental health disorders? Yes/No
Kidney Problems? Yes/No
Persistent swollen glands in neck? Yes/No
Severe headaches/ migraines? Yes/No

Has a physician or dentist recommended that you take antibiotics prior to dental treatment? Yes/No

If yes, list name and phone number of physician or dentist making recommendations:
_____

Do you have any disease, condition, or problem not listed that you think we should know about? Yes/No

If yes, please list: _____

P**atient / Legal Guardian Signature: _____ Date: _____**