International Community Health Services
P.O. Box 3007
Seattle, WA 98114-3007
(206) 788-3700

HEALTH HISTORY

☐ Male ☐ Female

Name of Patient: _____ Birthdate: _____

Phone Number: _____ Preferred Language: _____

Address: _____

Ethnicity: ☐ American Indian / Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ More than one race ☐ Prefer not to list

Name of Physician: _____ Date of last physical: _____

Is the patient now under the care of a physician? YES NO

If yes, for what reason? _____

Is the patient presently taking any medications/drugs/pills? YES NO

If yes, please list:_____

Is the patient allergic (or has an adverse reaction) to any medications? YES NO

If yes, please explain: _____

Is the patient sensitive or allergic to latex? YES NO

Has the patient had any unusual or unexplained reactions during a surgical procedure? YES NO

If yes, please explain: _____

Patient has dental insurance (including Medicaid, SCHIP, etc.) YES NO

Name of Insurance Company: _____

Name of Subscriber: _____ Relationship to Patient: _____

Policy #: _____ Group #: _____ Subscriber's Date of Birth: _____

Effective Date: _____ Expiration Date: _____ Customer Service Phone #: _____

Has the patient ever experienced any of the following? (Please check all that apply.)

Abnormal Blood Pressure	☐	Epilepsy	☐	Osteoporosis	☐
Attention Deficit Disorder (ADD)	☐	Fainting Spells	☐	Prolonged Bleeding	☐
Alcohol Addiction	☐	GI Problems (GERD)	☐	Prosthetic Implants	☐
Anemia	☐	Glaucoma	☐	Psychiatric Care	☐
Arthritis/Rheumatism	☐	Hearing Impaired	☐	Removal of Spleen	☐
Artificial Heart Valve	☐	Heart Disease/Surgery	☐	Rheumatic Fever	☐
Artificial Joint	☐	Heart Murmur	☐	Rheumatic Heart Disease	☐
Asthma	☐	Heart Pace Maker	☐	Sickle Cell Disease	☐
Autoimmune (Lupus/MS)	☐	Hemophilia	☐	Sinus Trouble	☐
Cancer	☐	Hepatitis ☐ A ☐ B ☐ C	☐	Stroke	☐
Radiation Therapy	☐	HIV Positive/AIDS	☐	Thyroid Problem	☐
Chemotherapy	☐	Kidney Problems/Dialysis	☐	Tuberculosis	☐
Cholesterol	☐	Learning Disability	☐	Tumors	☐
Congenital Heart Disease	☐	Liver Disease	☐	Ulcers	☐
Diabetes	☐	Lung Disease	☐	Sexually Transmitted Infection (STI)	☐
Eating Disorder	☐	Mitral Valve Prolapse	☐	Wheel Chair	☐
Recreational Drug Use	☐	Neurological Disorders	☐	Sudden Weight loss/gain	☐
Emphysema	☐	Organ Transplant	☐		

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Has the patient had any other serious illness, hospitalization, or accident? YES NO

If yes, please explain: _____

Does the patient currently smoke or use the following tobacco products?

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ None

Has the patient used tobacco in the past? YES NO If yes, how long ago? _____

Does the patient drink alcoholic beverages? YES NO If yes, how much? _____

Are the patient's immunizations up-to-date? YES NO

FEMALE PATIENTS, please circle YES or NO.
Is she pregnant? YES NO Is she breast feeding? YES NO Is she using birth control medications? YES NO

Comments:

DENTAL HISTORY

Date of Last Dental Visit: _____

Please check all that apply to the patient.	**YES**
Do the patient's gums bleed while brushing or flossing?	☐
Are the patient's teeth sensitive to hot or cold liquids/foods?	☐
Are the patient's teeth sensitive to sweet or sour liquids/foods?	☐
Does the patient feel pain to any of his/her teeth?	☐
Does the patient have any sores or lumps in or near his/her mouth?	☐
Has the patient had any head, neck, or jaw injuries?	☐
Does the patient have frequent headaches?	☐
Does the patient clench or grind his/her teeth?	☐
Does the patient bite his/her lips or cheeks frequently?	☐
Has the patient ever experienced any of the following?	☐

☐ Clicking in jaw ☐ Pain (joint, ear, side of face) ☐ Difficulty in opening or closing mouth
☐ Difficulty in chewing

Has the patient had any orthodontic work?	☐
Has the patient ever had prolonged bleeding following extractions?	☐
Has the patient ever had instruction on the correct method of brushing his/her teeth?	☐
Has the patient ever had instruction on the care of his/her gums?	☐

Comments: