Health History Form

Date: Arrival Time:

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Daytime Phone #: _____ Alternate Phone #: _____

language: _____ Height: _____Weight: _____ Dominant Hand: ❑ Right ❑ Left

OTHER / REFERRING DOCTORS: please list the Doctors you would like records sent to

Name of Doctor	Specialty	Phone Number	Fax	Address

UNDERSTANDING YOUR CURRENT PAIN: *(Reason for visit)*

Describe in ***your own words*** the pain problem(s) you would like help with:

Is nausea associated with your pain? ❑ Yes ❑ No

Is vomiting associated with your pain? ❑ Yes ❑ No

Does your pain increase with bright lights? ❑ Yes ❑ No

Does your pain increase with loud noises? ❑ Yes ❑ No

Does physical activity make your pain: (check one) ❑ better ❑ worse ❑ no change

Do you get an aura (flashing lights, zigzags, blindness, smells)? ❑ Yes ❑ No

*If Yes, (describe): _

Does your pain wake you from sleep? ❑ Yes ❑ No

Does your pain keep you from falling asleep? ❑ Yes ❑ No

Do any of your family members have the same or similar pain problem? ❑ Yes ❑ No

Do any of these occur with your pain? (check all that apply)

❑ Redness of the eye(s) ❑ Eyelid drooping

❑ Tearing of the eye(s) ❑ Nasal stuffiness ❑ Facial sweating

Do you have difficulty opening or closing your mouth? ❑ Yes ❑ No

Do you hear clicking or popping in your jaw joints? ❑ Yes ❑ No

CURRENT MEDICATIONS:

List all medications you are currently taking for medical and pain problems including prescribed, over-the-counter, herbs, vitamins. Do not bring your medicines to the clinic unless you have a question to discuss with the physicians.

Name	Pill Strength	# of times taken per day	Doctor who prescribed	Date started

HISTORY OF YOUR PAIN:

When did your pain start?

_____

When did your pain become a problem?

_____

What event(s) led to your present pain?

❑ Accident ❑ Other injury ❑ Other disease ❑ No obvious cause

❑ Cancer ❑ Following an operation ❑ Other: _

What do **YOU** think is the cause of your pain? _____

EFFECTS OF PAIN:

Circle the number to indicate how much your pain has interfered with your activities this **past week.**

0 1 2 3 4 5 6 7 8 9 10

No Interference — Mild Interference — Moderate Interference — Severe Interference — Complete Interference

Previous Doctors

List ALL of the doctors you have seen for your pain problem

Date	Name	Specialty	Address / Phone / Fax

PREVIOUS MEDICATIONS: List all previous medications you have taken for pain:

Name of Medicine	Dose	Dates of Use	Helpful	Reason for stopping
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	
			❑ Yes ❑ No	

PREVIOUS TREATMENTS:

Indicate which of the following treatments you have tried for your pain problem:

❑ Nerve Blocks ❑ Chiropractor ❑ Psychotherapy ❑ Relaxation Training

❑ Acupuncture ❑ Physical Therapy ❑ Biofeedback ❑ Exercise Program

❑ Other (list): _

DIAGNOSTIC TESTS:

Please list, in chronological order, all tests and x-rays performed to evaluate your pain:

Date	Test	Results

PAST MEDICAL PROBLEMS, SURGERIES, HOSPITALIZATIONS OR INJURIES:

Year	Describe	Hospital	Doctor

ALLERGIES: ❑ No Known Allergies

REVIEW OF SYSTEMS:

Please check if you have **or** had any of the following:

General
- ❑ Weight loss
- ❑ Poor appetite
- ❑ Severe fatigue / low energy
- ❑ Cancer

Hematological
- ❑ Anemia
- ❑ Easy bruising
- ❑ Bleeding disorder
- ❑ Taking blood thinners
- ❑ Blood Transfusion:
  - ❑ Yes ❑ No

Reaction:

Skin
- ❑ Rash
- ❑ Nail changes
- ❑ Bumps / nodules

Head and Neck
- ❑ Headaches
- ❑ Visual changes
- ❑ Mouth problems
- ❑ Neck pain
- ❑ TMJ problems

Cardiac
- ❑ Exercise limitations
- ❑ Chest pain
- ❑ Irregular heartbeat
- ❑ Heart murmurs
- ❑ High or low blood pressure
- ❑ Circulation problems
- ❑ Ankle swelling

Pulmonary
- ❑ Shortness of breath
- ❑ Cough
- ❑ Asthma or bronchitis
- ❑ Lung disease
- ❑ Sleep apnea
- ❑ Snoring

Endocrine
- ❑ Diabetes
- ❑ Thyroid problems

Gastrointestinal
- ❑ Abdominal Pain
- ❑ Nausea or vomiting
- ❑ Constipation
- ❑ Diarrhea
- ❑ History of ulcers or heartburn

Genitourinary
- ❑ Frequent or hesitant urination
- ❑ Pain with urination
- ❑ Blood in urine
- ❑ Incontinence
- ❑ Sexual dysfunction

Musculoskeletal
- ❑ Arthritis -Type:
- ❑ Osteoporosis
- ❑ Muscle pain
- ❑ Muscle wasting
- ❑ Fractures

Neurologic
- ❑ Numbness
- ❑ Weakness
- ❑ Falling
- ❑ Stroke
- ❑ Seizures
- ❑ Memory Loss
- ❑ Loss of balance

Infectious Diseases
(check all that apply)
- ❑ Measles ❑ Mumps
- ❑ Chicken Pox
- ❑ Rheumatic fever
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ Other:
- ❑ HIV ❑ AIDS
- ❑ Herpes (Oral)
- ❑ Herpes (Genital)
- ❑ Shingles
- ❑ Post-herpatic neuralgia

In the last 5 years:
Received:
Pneumovax: ❑ Yes ❑ No
Flu shot: ❑ Yes ❑ No

Gynecologic
- ❑ Pregnant
- ❑ Post-menopausal:

Last Menstrual Period:

HABITS:

Smoking: ❑ Yes ❑ No ❑ Quit Packs per day: Number of years smoked:

Alcohol use: ❑ None ❑ Occasional ❑ Daily How much per week?

Are you currently using recreational drugs? ❑ No ❑ Yes: ❑ Amphetamines ❑ Cocaine ❑ Heroin ❑ Marijuana ❑ Other:

Do you drink caffeine (coffee, tea, etc.)? How many cups per day?

Do you clench your teeth? ❑ Yes ❑ No

Do you grind your teeth? ❑ Yes ❑ No

Do you wear a night guard over your teeth? ❑ Yes ❑ No

EXERCISE:

Do you exercise? ❑ No ❑ Yes, what type?

How many days per week do you exercise?

How long do you exercise each time (on average)?

FAMILY HISTORY: Are you adopted? ❑ Yes ❑ No

Member	Deceased or Living		Age	Medical Problems
Father	❑	❑		
Mother	❑	❑		
Siblings	❑	❑		
	❑	❑		
	❑	❑		
	❑	❑		
Spouse	❑	❑		

SOCIAL HISTORY:

Relationship Status: ❑ Single ❑ Separated ❑ Married ❑ Widowed ❑ Domestic Partner: ❑ Female ❑ Male

With whom do you live? Name: _____ Relationship: _____

Highest level of education completed: ❑ Less than High School ❑ High School ❑ Vocational ❑ Graduate ❑ College ❑ Other: _

Current or most recent occupation: _____

Status: ❑ Full Time ❑ Part time ❑ Self-employed ❑ Homemaker ❑ Retired # years: ❑ Unemployed years due to pain ❑ Unemployed years due to: _

Are you happy with your job? ❑ Yes ❑ No

Are you on Disability? ❑ No ❑ Yes, Date Started: _____

Reason for disability: _____

PSYCHOLOGICAL HISTORY:

Describe your mood: _____

_____

Do you have problems with any of the following:

❑ Concentration ❑ Motivation ❑ Sleep ❑ Appetite ❑ Anxiety

❑ Depression ❑ Self-worth ❑ Homicidal thoughts ❑ Suicidal thoughts

Do you have a history of physical or mental abuse? ❑ Yes ❑ No

Are you currently in therapy? ❑ No ❑ Yes, who do you see? Phone # _____

FINANCIAL INFORMATION:

Do you have any legal action pending related to this pain or any other health problem?

❑ No ❑ Yes, Attorney's name: _____ Phone # _____

Address: _____

HEALTH CARE DECISIONS: *(Check boxes that apply)*

❑ Patient prefers to make own medical decisions.

❑ Medical decisions are made jointly between patient and family.

❑ Patient prefers family members to make the major medical decisions.

❑ Patient has Advance Directives: ❑ Yes ❑ No

* If Yes, Copy of Directives given to CSMC: ❑ Yes ❑ No

Source of information if other than patient:

_____

Signature of person acquiring this information

_____

Signature of patient: Date: _____

Evaluation reviewed by Physician:

_____ _____ _____ _____

Name of Physician (*please print*) Signature of Physician ID# Date Signed

For Clinical Use Only:

Blood Pressure: / Heart Rate: Respiration Rate: _

Yogi Dental Center

30 Scotland Rd Orange Nj 07050
yogidental@gmail.com
973-673-1311

Practice Name: _____
Patient Identification Number: _____
Birth Date: _____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1.	Yes	No	Is your general health good?
2.	Yes	No	Has there been a change in your health within the last year?
3.	Yes	No	Have you been hospitalized or had a serious illness in the last three years? If YES, why?
4.	Yes	No	Are you being treated by a physician now? For what? _____

Date of last medical exam? _____ Date of last Dental exam? _____

5.	Yes	No	Have you had problems with prior dental treatment?
6.	Yes	No	Are you in pain now?
7.	Yes	No	Chest pain (angina)?
8.	Yes	No	Swollen ankles?
9.	Yes	No	Shortness of breath?
10.	Yes	No	Recent weight loss, fever, night sweats?
11.	Yes	No	Persistent cough, coughing up blood?
12.	Yes	No	Bleeding problems, bruising easily?
13.	Yes	No	Sinus problems?
14.	Yes	No	Difficulty swallowing?
15.	Yes	No	Diarrhea, constipation, blood in stools?
16.	Yes	No	Frequent vomiting, nausea?
17.	Yes	No	Difficulty urinating, blood in urine?
18.	Yes	No	Dizziness?
19.	Yes	No	Ringing in ears?
20.	Yes	No	Headaches?
21.	Yes	No	Fainting spells?
22.	Yes	No	Blurred vision?
23.	Yes	No	Seizures?
24.	Yes	No	Excessive thirst?
25.	Yes	No	Frequent urination?
26.	Yes	No	Dry mouth?
27.	Yes	No	Jaundice?
28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?
30.	Yes	No	Heart attack, heart defects?
31.	Yes	No	Heart murmurs?
32.	Yes	No	Rheumatic fever?
33.	Yes	No	Stroke, hardening of arteries?
34.	Yes	No	High blood pressure?

35. Yes No Asthma, TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: drugs, foods, medications, latex? Disease?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal
50. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

V. ARE YOU TAKING:

61. Yes No Recreational drugs?
62. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?

Please list: _____

63. Yes No Tobacco in any form?
64. Yes No Alcohol?
65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?
67. Yes No Do you have or have you had any other diseases/medical problems NOT listed on here?

If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____

Patient's signature: Date:

Authorization for YOGI DENAL CENTER to Use or Disclose My Health Care Information

Patient name: _____ Date of birth: _____

Previous name: _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- ☐ All health care information in my medical record
- ☐ Health care information in my medical record relating to the following treatment or condition: _____
- ☐ Health care information in my medical record for the date(s): _____
- ☐ Other (e.g., X rays, bills), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- ☐ HIV (AIDS virus)
- ☐ Sexually transmitted diseases
- ☐ Psychiatric disorders/mental health
- ☐ Drug and/or alcohol use

You may disclose this health care information to:

Name (or title) and organization or class of persons: _____

Address (optional): _____ City: _____ State: _____ Zip: _____

Reason(s) for this authorization (check all that apply):

- ☐ at my request
- ☐ other (specify) _____
- ☐ check only if [practice/ facility]requests the authorization for marketing purposes
- ☐ check only if [practice/facility] will be paid or get something of value for providing health information for marketing purposes

This authorization ends:

- ☐ on (date): _____
- ☐ when the following event occurs: _____
- ☐ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health care information for a third party.

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by [name of practice or health care facility] based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available from the [practice/health care facility]. Or
- Write a letter to the [practice/health care facility].

Once health care information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature | Date | Time

_____ _____

Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative)

Last Update:____/____/____