HOPE CLINIC OF ROSS COUNTY

Place printed label here

Physical Health History

Patient Number _____ New Patient _____ Returning Patient (last visit 12 months or longer) _____
Name _____ Gender: Female _____ Male _____
Address _____ City_____ Zip _____
Phone(s)_____ Date of birth_____ Age _____
Email _____
Emergency Contact/Phone Number _____
Weight: (to be recorded by Hope Clinic staff) _____

REASON FOR VISIT _____
Name of Family Doctor/ Clinic and Dentist: _____
Date of last physical _____ Date of last dental check up _____
Are you currently being treated (by Doctor or Dentist)? Yes____ No____ Doctor's Name _____
Medication or other allergies: _____Yes _____No List: _____
_____
Smoker: ___ Yes ____ No How many packs per day? _____ For how many years? _____
Are you pregnant? ___Yes ____No Are you breastfeeding? ___Yes ____No Date of last period: _____

MEDICAL HISTORY: Please check YES or NO for EACH of the following

	YES	NO		YES	NO		YES	NO		YES	NO		YES	NO
Alcohol/Drug Abuse			Heart Attack			Blood Disease			Migraines			Heart Problems		
Smoking			Rheumatic Fever			Anemia			Seizures/Epliepsy			Heart Valve Replacement		
Emphysema			Urine Infection			Recent Weight Loss			Psychiatric Problems			Low Blood Pressure		
Asthma			Kidney Stones/Disease			Cancer			Nerve Problems			High Blood Pressure		
Bronchitis			HIV+AIDS			Abnormal bleeding			Depression			Stroke		
Pneumonia			Genital Herpes			Colitis			Anxiety			Fainting		
Tuberculosis			Gonorrhea/Syphilis			Bloody Stools			Lupus			Thyroid/Goiter		
Birth Defects			Hepatitis A,B, or C			Hemorrhoids			Rheumatoid Arthritis			Diabetes		
Heart Murmur			Genital Warts			Gallbladder Disease			Osteo-arthritis			Aneurysm		
Ulcers			Jaundice			Liver Disease			Prosthetic Joint			Joint Replacement		
Glaucoma			Macular Degeneration			Cataracts			Other:			Other:		

Past surgeries/hospitalizations: _____

Signature _____ Date _____