KNOX COUNTY COMMUNITY Health Center KNOX PUBLIC HEALTH

Patient Medical and Dental History

Today's Date: ________________________

Patient's Name: ____ Date of Birth: ________________________

Allergies: I do not have any allergies. ___________ (Initial)

I have the following drug, environmental or food allergies (Write name and effect you had)

Drug / Environmental / Food Allergy	***What happens*? (reaction)**

Are you currently pregnant? No Yes

Would you like to become pregnant within the next 12 months? No Yes

Medical History: Check if you have or have had problems / history with any of the following:

Cardiac
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Irregular Heart Beat
- Stroke / TIA
- Heart Transplant
- Artificial Heart Valves
- Pacemaker

Circulatory
- Amputee
- Blood Clots
- Peripheral Artery Disease
- Peripheral Vascular Disease

Dental
- Bleeding Gums
- Grinding Teeth
- Loose Teeth / Broken Fillings
- Periodental Treatment
- Tooth Sensitivity

Endocrine
- Thyroid Disease
- Diabetes

Gastroenterology
- Bleeding Ulcers
- Diverticulitis
- Gallbladder
- GERD
- Hernia

Immune
- Lupus
- Rheumatoid Arthritis

Infectious Disease
- HIV
- MRSA
- VRE
- Hepatitis

Lungs
- Asthma
- COPD
- Obstructive Sleep Apnea
- Pulmonary Embolism
- Tuberculosis
- Lungs

Neurology
- Seizures

Mental / Behavioral Health
- ADD / ADHD
- Anxiety
- Depression
- Traumatic Event / PTSD
- Other: _______________
- Additions:____________

Musculoskeletal
- Arthritis
- Gout
- Open Wounds
- Osteoprorsis

Renal
- Dialysis
- Kidney Disease

Cancer
- No history of cancer
- Yes, prior history of cancer
- If Yes: Type: _____________
  ____

Surgeries:

Example: Right knee replacement	*When?* 6 years ago

Signature of Patient or Parent/Guardian (If patient is minor): ______________________________________ **Date** _________________

Revised: 9/2017; 9/2018; 08/2022; 06/2024