JORDAN VALLEY COMMUNITY HEALTH CENTER Name ____ Date of Birth ____ / ____ / ______

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience.

- ❑ Abdominal pain ____/____/____
- ❑ ADD / ADHD ____/____/____
- ❑ Allergies ____/____/____
- ❑ Anemia ____/____/____
- ❑ Anxiety ____/____/____
- ❑ Arthritis ____/____/____
  Location:_____________
- ❑ Artificial heart valve ____/____/____
- ❑ Asthma ____/____/____
  Rescue inhaler Yes/No
- ❑ Atrial fibrillation ____/____/____
- ❑ Autism/Asperger's ____/____/____
- ❑ Blood clots ____/____/____
- ❑ Breastfeeding ____/____/____
- ❑ Bronchitis ____/____/____
- ❑ Bruise easily/ Excessive bleeding ____/____/____
- ❑ Cancer ____/____/____
  Type: ________________
- ❑ Chemotherapy/ ____/____/____
  Radiation Treatment ____/____/____
- ❑ Chest Pain ____/____/____
- ❑ Chicken pox ____/____/____
- ❑ Cognitively Developmentally Disabled ____/____/____
- ❑ Cold sores / Fever blisters ____/____/____
- ❑ Concussion ____/____/____
- ❑ Convulsions / Epilepsy ____/____/____
- ❑ Cortisone/steroid Medicine ____/____/____
- ❑ Coronary artery disease ____/____/____
- ❑ Crohn's disease ____/____/____
- ❑ Cystic Fibrosis ____/____/____
- ❑ Depression ____/____/____
- ❑ Diabetes ____/____/____
- ❑ Dizziness/Fainting spells ____/____/____
- ❑ Down's syndrome ____/____/____
- ❑ Emphysema ____/____/____
- ❑ Gallbladder disease ____/____/____
- ❑ Hearing problems ____/____/____
- ❑ Heart attack ____/____/____
- ❑ Heart murmur ____/____/____
- ❑ Heart trouble/disease ____/____/____
- ❑ Heartburn ____/____/____
- ❑ Hemophilia ____/____/____
- ❑ Hepatitis ____/____/____
  Type:_______________
- ❑ Herpes ____/____/____
- ❑ High blood pressure ____/____/____
- ❑ High Cholesterol ____/____/____
- ❑ History of endocarditis ____/____/____
- ❑ HIV ____/____/____
- ❑ Irregular heart beat ____/____/____
- ❑ Irritable bowel disease ____/____/____
- ❑ Jaw pain ____/____/____
- ❑ Kidney disease ____/____/____
- ❑ Learning disability ____/____/____
- ❑ Liver disease ____/____/____
- ❑ Malignant Hyperthermia ____/____/____
- ❑ Migraine headaches ____/____/____
- ❑ Mitral valve prolapse ____/____/____
- ❑ MRSA infection ____/____/____
- ❑ Osteoporosis ____/____/____
- ❑ Pneumonia ____/____/____
- ❑ Pregnancy ____/____/____
- ❑ Psychiatric care ____/____/____
- ❑ Radiation to head/neck ____/____/____
- ❑ Sinus trouble ____/____/____
- ❑ Spina bifida ____/____/____
- ❑ STD's ____/____/____
  Type: _______________
- ❑ Stomach ulcer ____/____/____
- ❑ Stroke ____/____/____
- ❑ Taken or taking bone density Medications ____/____/____
- ❑ Taken Phen-Fen Or Redux ____/____/____
- ❑ Taking blood thinners ____/____/____
- ❑ Thyroid disease ____/____/____
- ❑ Trauma to head/neck ____/____/____
- ❑ Vision problems ____/____/____

Other:

- ___________________ ____/____/____
- ___________________ ____/____/____
- ___________________ ____/____/____
- ___________________ ____/____/____
- ___________________ ____/____/____

Surgical History

Please check all that apply.

- ❑ Angioplasty ____/____/____
- ❑ Congenital heart Conditions ____/____/____ ____/____/____
- ❑ Ear tubes ____/____/____
- ❑ Family History of problems with anesthesia ____/____/____
- ❑ Heart Stent ____/____/____
- ❑ Heart surgery ____/____/____
- ❑ Heart transplant ____/____/____
- ❑ Heart valve problems
- ❑ Hip replacement ____/____/____
- ❑ Knee replacement ____/____/____
- ❑ Other joint replacement ____/____/____
- ❑ Tonsil/adenoid removal ____/____/____
- ❑ Other Hospitalizations/ Surgeries
  - ___________________ ____/____/____
  - ___________________ ____/____/____
  - ___________________ ____/____/____
  - ___________________ ____/____/____
  - ___________________ ____/____/____
  - ___________________ ____/____/____

By participating in certain federal programs we are required to request the following information about patients **aged 12 and older**.

Sex at Birth

- ❑ Male
- ❑ Female
- ❑ Unknown
- ❑ Decline to Specify

Gender Identity

- ❑ Male
- ❑ Female
- ❑ Female to Male
- ❑ Male to Female
- ❑ Gender Neutral
- ❑ Decline to Specify
- ❑ Other: ________________________

Sexual Orientation

- ❑ Homosexual
- ❑ Heterosexual
- ❑ Bisexual
- ❑ Something Else
- ❑ Don't Know
- ❑ Decline to Specify

JORDAN VALLEY COMMUNITY HEALTH CENTER Name ______________________________ Date of Birth ____ / ____ / ______

Pediatric History

Parents/siblings with cavities?	❑ Yes	❑ No
Fluoride in water?	❑ Yes	❑ No
Uses a sippy cup?	❑ Yes	❑ No
Child is put to bed with a bottle or sippy cup?	❑ Yes	❑ No
Fluoride toothpaste used?	❑ Yes	❑ No
Uses a pacifier?	❑ Yes	❑ No
Sucks thumb/finger?	❑ Yes	❑ No
Times per day teeth are brushed	___________	

Pediatrician-Location and Provider ____

Social History

Do you use tobacco? ❑ Yes ❑ No ❑ Former Type of tobacco used? ______________/_______________
Packs per day? ____________________________________ Years smoked? _________________ Year Quit? _____________

Do you drink alcohol? ❑ Yes ❑ No ❑ Former Year Quit? ____________
How much per week? ____________ Last Drink? ____________

Drug Use Abuse

Have you ever used illegal drugs? ❑ Yes ❑ No ❑ Formerly Type ________________

Medications/Herbal Supplements

Medication ❑ No medications

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

Allergies

Allergy ❑ No known allergies

1.	4.
2.	5.
3.	6.

Birth History

Maternal illness / complications ❑ Yes ❑ No
Type: ______________
Premature Birth ❑ Yes ❑ No
Birth weight ____lbs ____oz

Stayed in NICU ❑ Yes ❑ No
Intubation in NICU ❑ Yes ❑ No
Feeding history ❑ Breast ❑ Bottle ❑ Both