Patient Name:_____

AXISHealth System

PATIENT HISTORY (*PLEASE COMPLETE ALL PAGES*)

Your answers on this form will help your healthcare team obtain an accurate history of you or your child's medical concerns and conditions. Please do your best to complete all pages. If you cannot remember specific details or if you have questions/concerns about the information we are requesting, please speak with your healthcare team.

Current Healthcare Provider		
Do you have a previous Primary Care Provider?	☐ Yes ☐ No (check one)	*If Yes – please list:*
Do you have a previous Dental Care Provider?	☐ Yes ☐ No (check one)	*If Yes – please list:*

Allergies:

Source: (medications, pollens, food, animals, other)	Type of reaction:

Current Medications: (include prescriptions, over the counter, supplements, vitamins, and herbs)

Name of Drug	Dose	Times Per Day	Reason	Prescribed By

Preferred Pharmacy:_____

Health Maintenance:	Yes	No
Dental visit in the past year?		
Vision check in the past year?		
Medical Provider visit this year?		

Immunizations:

Please check off any vaccinations you have had and list the year if known.

Vaccination:	Year:	Vaccination:	Year:
Flu Shot		Pneumonia (P13, P23)	
Hepatitis A		Shingles (Shingrix, Zostavax)	
Hepatitis B		Tetanus	
HPV		Tetanus w/ Pertussis (DTAP, TDaP)	
MMR		Varicella (Chicken Pox) Shot	
Polio		H. Influenza	
Meningitis		Other:	
Covid			

Hospitalization and Surgical History (include psychiatric):

Reason:	Date	Location	Overnight Stay?

Patient Name:_____

AXISHealth System

Have you had any of the following screening tests?

Test Type:	Completed/Obtained	Date	Testing Location	Result (*please circle*)
Colonoscopy	☐ Yes or No ☐			Normal ☐ Abnormal ☐
Dexa (Bone Density) Scan	☐ Yes or No ☐			Normal ☐ Abnormal ☐
Heart tests: Catheterization, stress test, echo	☐ Yes or No ☐			Normal ☐ Abnormal ☐
Mammogram	☐ Yes or No ☐			Normal ☐ Abnormal ☐
Pap	☐ Yes or No ☐			Normal ☐ Abnormal ☐
Hepatitis A, B or C (blood test)	☐ Yes or No ☐			Normal ☐ Abnormal ☐
HIV/AIDS (blood test)	☐ Yes or No ☐			Normal ☐ Abnormal ☐
Herpes Simplex I and II (blood test)	☐ Yes or No ☐			Normal ☐ Abnormal ☐

Past and Current Medical Conditions: Please indicate with an **X** if you have had the following:

	Skin Condition		**Neurology**
	Eczema/Psoriasis		Migraine or headaches
	Eyes/Ears		Seizures or fainting spells
	Blindness		Epilepsy
	Hearing Loss		Traumatic brain injury / concussion
	Respiratory		Developmental Delay
	Asthma		Stroke date:
	Pneumonia		**Gastrointestinal**
	Cardiovascular		Irritable bowel / Ulcerative colitis / Crohn's
	Hypertension		**Musculoskeletal**
	High cholesterol		Back/neck injury
	Heart disease		Arthritis
	Heart Attack		Osteoporosis
	Heart Valve replacement		**Urological/Renal**
	Endocrinology		Kidney Stones
	Diabetes Type 1		Chronic kidney disease
	Diabetes Type 2		Frequent Urinary Tract Infection
	Thyroid Problems		**Emotional / Behavioral**
	Blood Conditions		ADHD
	Anemia		Learning Disability
	Bleeding / clotting problems		Depression
	Cancer: Diagnosis and Date		Alcohol or Drug Abuse
	Chemotherapy (past or current)		Anxiety
	Radiation treatment (past or current)		Eating Disorders
	Infectious Diseases		Mental Illness
	Hepatitis A, B, or C (please circle which one)		Diagnosis
	HIV/AIDS		**Other Condition: (Please specify)**
	Herpes Simplex I or II		

Family History: Please indicate with an X if a family member has one of the following conditions:

Condition	Mother	Father	Siblings	Grandparents
Heart Disease				
High Blood Pressure				
Cancer (Breast, Ovarian, Colon, Prostate)				
Diabetes				
Glaucoma				
Mental Illness				
Stroke				

Patient Name:_____

AXISHealth System

For the following questions, please answer to the best of your ability and/or address with your Provider.

Sexual Activity:

Sexually Active (check box): ☐ Yes ☐ No ☐ Prefer not to discuss

Sexual partner(s) is/are/have been (please check box): ☐ Female ☐ Male ☐ Prefer not to discuss

Birth Control Method (circle all that apply): Condom, Pill, Diaphragm, Other:_____

Number of sexual partners in the past year? _____

Lifestyle Information: Tobacco Use and or Vaping/E-Cigarettes:

Smoking Status (*check one*):

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoked

Current Smoker: Pack/Day:____# of Years:_____

Use Details:

Quit date:_____How many years did you smoke:_____How many packs/day did you smoke?____

Other tobacco (please check all that apply): ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew ☐ E-Cigarettes

Have you attempted to quit (check one): ☐ Yes ☐ No

Alternative Treatments:

☐ Acupuncture ☐ Medical Marijuana ☐ Massage ☐ Naturopathic Remedies

☐ Other:_____

Dental information:	**Yes**	**No**	**Don't Know**
Do your gums bleed when you brush or floss?			
Are your teeth sensitive to cold, hot, sweets, or pressure?			
Does food or floss catch between your teeth?			
Is your mouth dry?			
Have you had any specialized periodontal (gum) treatments ?			
Have you ever had orthodontic (braces) treatment?			
Have you had any problems associated with previous dental treatment?			
If yes, Explain:			
Are you currently experiencing dental pain or discomfort?			
Do you have earaches or neck pains?			
Do you have any clicking, popping, or discomfort in the jaw?			
Do you grind your teeth?			
Do you have sores, ulcers, or cold sores in your mouth?			
Do you wear dentures or partials?			
Do you have any dexterity issues that lead to challenges with oral hygiene?			
Have you ever had a serious injury to your head or mouth?			
Are you taking or scheduled to begin taking any medications for osteoporosis, bone pain, hypercalcemia, (or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer)? Eg. alendronate (Fosamax), Boniva, risedronate (Actonel) or Denosumabs like Xgeva, Prolia, (Zoledronic Acid (Reclast or Zometa) or pamidronate (Aredia)			
Have you had any orthopedic total joint replacement?			
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			
Are you currently on a '**blood thinner**' such as Warfarin, Coumadin, Xarelto, Plavix/clopidogrel (check NO if just taking aspirin)			
Are you immunocompromised or are you taking any medications that suppress your immune system (eg medications after organ transplant, immunosuppressant drugs for cancer etc)?			