Exalta Health
Medical/Family/Social/Dental Histories

Name:____

Date:____/______/____Date of Birth/____/______/______

Please circle or fill in your response to the best of your ability

Medical/Family History

1.) Are you allergic to any medications? YES NO For example: antibiotics, pain medications, local anesthetics

NAME REACTION

____

____

____

____

2.) Have you ever been told that you have any of the following? Please circle all that apply:

Anxiety	Diabetes	Stroke
Arthritis	Heart disease	Substance use
Bleeding problems	High blood pressure	Thyroid problems
Cancer	High cholesterol	Other_____________________
Chemotherapy	Kidney problems	
Depression/	Liver problems	

3.) If you circled any of these problems, please write an explanation along with approximate date of diagnosis:

PROBLEM DATE OF DIANOSIS

____

____

____

4.) Have any of your immediate family members (parents/brothers/sisters/grandparents) been told they have any of the following? Please circle all that apply.

Anxiety	Diabetes	Liver problems
Arthritis	Early deaths	Stroke
Bleeding problems	Heart disease	Substance use
Cancer	High blood pressure	Thyroid problems
Chemotherapy	High cholesterol	Other______________
Depression	Kidney problems	

5.) If you circled any of these problems, please write an explanation:

RELATION PROBLEM

____

____

____

____

____

____

6.) Have you ever had surgery or an operation? Have you ever stayed overnight in the hospital? Please write down the approximate date and reason for hospitalization (medical or psychological). Please include any operations or surgeries

DATE REASON

____

____

____

____

____

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____

Social History

7.) Do you currently or in the past use any tobacco and/or nicotine products of any kind? YES NO

If yes, what products do you use? Circle all that apply. Indicate amount and frequency of use:

Cigarette, cigarillo, cigar, pipe:_____Amount & frequency:____________________________

E-cigarettes, hookah, vape juice, shisha, other inhalants:_____Amount & frequency:_________________

Chew, spit, snuff, snuffs: ____ Amount & frequency: _____________________________________

Strips, sticks, orbs, discs, other dissovables: ____ Amount & frequency:_______________________

8.) How many years have you used any of these tobacco products?___________________

9.) In general, how would you rate your health: Excellent Very good Fair Poor

10.) What is your general stress level: Low Medium High

11.) How much do you exercise? Please choose from the following categories: None

Occasional (30 min. 3-5 days/week) Moderate (60 min. 3-5 days/week) Heavy (90 min 3-5 days per week)

12.) Do you have a consistent supply of home medications? YES NO

If no, please explain:____

13.) How often do you drink alcohol? Daily____ Amount ______________________________________

Weekly but less than daily___ Amount & frequency____

Monthly but less than weekly ___Amount & frequency____

If yes, when was your last drink?________________Never____If never, have you ever drank?_________

14.) How often do you use drugs other than alcohol including recreational and street drugs?

Daily___________Never _____If never, have you ever used substances?________________________

Weekly but less than daily____Amount & frequency____

Monthly but less than weekly____Amount & frequency_______________________________________

If yes, when was your last time you used?____

Please indicate which substances you use:____

15.) Do you drink caffeinated beverages? YES NO If yes, how many per day?______________

16.) Are you sexually active? YES NO

17.) Do you have protected sex? Always Usually No

18.) What is your sexual orientation? Heterosexual Homosexual Bisexual Prefer not to answer

19.) What is your level of education: Less than 8th grade Some High school High school graduate

GED Some College College graduate Post-graduate degree

20.) Are you currently employed? YES NO If no are you seeking work? YES NO

If yes, please circle type of employment: Part time Seasonal Full time

21.) If employed what kind of work do you do?____

22.) Do you follow any type of diet? Regular Vegetarian Vegan Gluten-free Specific______________

23.) What is your marital status? Single Married Divorced Separated Widowed

24.) How many children do you have?________________________

25.) FEMALES ONLY: Number of pregnancies?________How many miscarriages?_______________

How many living children?____________________How many abortions? __________________

26.) Are you able to care for yourself? YES NO

27.) Do you live alone or with others? Alone With others

28.) Do you have a smoke alarm in your home? YES NO

29.) Do you have concerns about your hearing? YES NO If yes, please explain:___________________

30.) Do you have concerns about your eye sight? YES NO If yes, please explain:__________________

31.) Do you use a seat belt in the car? YES NO

32.) Do you use sunscreen? YES NO

33.) Is God, spirituality, religion, or spiritual faith important to you? YES NO

34.) Do you meet with others in a religious or spiritual community? YES NO

If so, how often?____

How do you integrate into your faith community?_______________________________________

What can we do to assist you in your medical care?_____________________________

Or, is there anything we can do to encourage your faith?_________________________________

May we pray with you? YES NO

Dental History

35.) Do you snore? YES NO DON'T KNOW

36.) Do you get drowsy when driving or in meetings? YES NO

37.) Do you get headaches in the morning? YES NO

38.) When was the last time that you had dental care?________________________________

What was the reason for seeking dental care?______________________________________

39.) Are you missing any teeth? YES NO Please circle all that apply:

Uppers: Wisdom (s) Front tooth / teeth Molar / molars All uppers

Lowers: Wisdom (s) Front tooth / teeth Molar / molars All lowers

Reasons for tooth loss: Not enough space Accident Decay Infection

40.) In the last 6 – 12 months, have you had any tooth, gum, or mouth pain? YES NO

41.) Do you have any false teeth, dentures, partials, bridges, caps, or implants? YES NO

42.) Do you drink pop, soda, sports drinks, energy drinks, or beverage mixes? YES NO

Amount per day / per week?____________________ Sip between meals? YES NO

43.) Do you have any untreated dental problems? YES NO DON'T KNOW

44.) Are you dissatisfied with the condition of your mouth? YES NO

45.) If you have teeth: Are your teeth in good condition? YES NO DON'T KNOW

a. When was the last time that you had your teeth cleaned? ______________________________

b. How often do you floss: I don't / Once in a while / # of times per week _______ Every day

c. Have you ever been shown how to floss? YES NO

d. Are any of your teeth sensitive to cold air, cold drink, hot drink, or to chewing? YES NO

e. Are any of your teeth misaligned or crowded? YES NO

f. Do you have any difficulty cleaning your teeth? YES NO

g. Do you have any trouble with: Bad breath? YES NO Dry mouth? YES NO

Thank you for completing this important health history information!