MedCity Family Clinic

Health History

Patient Name	Date of Birth	Height	Weight	Date
Nancy Ormondi	10/10/1988	53	149	03/24/2022

Answer all questions by circling Yes (Y) or No(N)

1. Are you in good health? ..... (Y) N
2. Have there been any changes to your general health in the past year? Lord ..... Y (N)
   If yes, please describe ----------
3. Date of last physical exam: 2020
4. Are you under a physician's care for a particular problem? ..... Y N
   Name of Primary Care Physician: _____ Y (N)
   Phone number of Primary Care Physician: _____
5. Have you ever had any serious illnesses, operations or hospitalizations? ..... (Y) N
   If yes, describe/list: Blood clot during pregnancy
6. Do you have any problems sleeping OR have you been told you stop breathing while sleeping or do you snore? ..... Y (N)

7. **DO YOU HAVE OR HAVE YOU EVER HAD:**

A. Congenital Heart Disease..... Y(N)

B. Cardiovascular Disease (heart attack, heart trouble, heart murmur, coronary artery disease, angina, high blood pressure, stroke, palpitations, heart surgery, pacemaker) ..... Y(N)

C. Artificial heart valves or artificial joints. Y(N)

D. Seizures, convulsions, epilepsy, fainting or dizziness..... Y(N)

E. Bleeding disorder, anemia, bleeding Tendency, blood transfusion. Do you Bruise easily?..... Y(N)

F. Liver disease (Jaundice, Hepatitis) ..... Y(N)

G. Kidney disease..... Y(N)

H. Dialysis..... Y(N)

I. Diabetes..... Y(N)

J. Arthritis..... Y(N)

K. Stomach Ulcers or colitis..... Y(N)

L. Cancer..... Y(N)

M. Lung disease (asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing) ..... Y(N)

N. Glaucoma..... Y N

O. Any disease, drug or transplant operation that depressed your immune system..... Y(N)

P. Clicking or popping of jaw joint, pain near ear, or difficulty opening mouth... Y(N)

Q. Osteoporosis..... Y(N)

R. Radiation (x-ray treatment) for cancer

S. Clench or grind your teeth..... Y(N)

T. Sinus or nasal problems..... Y(N)

U. HIV/AIDS..... Y(N)

V. Thyroid disease (Goiter)..... Y(N)

8. ARE YOU NOW USING ANY OF THE FOLLOWING:

A. Antibiotics..... Y (N)

B. Anticoagulants (blood thinners) ..... Y (N)
Aspirins or drugs such as Motrin, Aleve

C. Ibuprofen..... Y (N)

D. High blood pressure medications..... Y (N)

E. Steroids (cortisone, prednisone, etc.)..... Y (N)

F. Are you taking any medications, Supplements, vitamins, etc..... Y (N)

G. Insulin or oral anti-diabetic drugs..... Y (N)

H. Digitalis, Inderal Nitroglycerin or other heart drug..... Y (N)

I. Chemotherapy... ..... Y (N)

J. Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple Myeloma, other cancers (Reclast, Fosomax, Actonel, Boniva Aredia, Zometa)..... Y (N)

K. Have you ever been advised to not take a medication?.... ..... Y (N)

Please list all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals_____

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

A. Local anesthetic..... Y (N)
B. Penicillin..... Y (N)
C. Other antibiotics..... Y (N)
D. Aspirin or ibuprofen..... Y (N)
E. Codeine or other pain killers.. Y (N)
F. Latex or rubber products..... Y (N)
G. Metal of any kind..... Y (N)
H. Chemicals or jewelry (rash or sensitivity)..... Y (N)
I. Food products.. ..... Y (N)
J. Nitrous Oxide ("laughing gas") ..... Y (N)
K. Other allergies or reactions..... Y (N)

10. Do you smoke or chew tobacco? If yes, how much per day?..... ..... Y (N)

11. Is there any of alcohol or chemical dependency or emotional disorder that may affect how we care for you..... Y N

12. Have you had any serious problem associated with any previous dental treatment? ..... Y (N)
If yes, please describe :_____

13. Do you have any other disease, condition or problem not listed above you think the doctor should know about?..... ..... Y (N)
If yes, please describe: _____

14. FOR WOMEN ONLY:

A. Are you pregnant?..... ..... Y (N)
B. Are you nursing?..... ..... Y (N)
C. If you are using oral contraceptives, antibiotics(and some other medications) may interfere with the effectiveness of the oral contraceptive. Please consult with your physician for further guidance.

I Understand the importance of a truthful and complete Health History to assist my doctor in providing the best care possible. I've had the opportunity to discus my health history with my doctor

03/24/2022 _____ _____
Date **Patient/Guardian Signature** **Doctor Signature**

IENT INFORMATION

Nancy Omondi Birthdate 10/10/1988 Home Phone (443) 678-8692

ss 149 Attenborough Dr City Rosedale State MD Zip 21237

☐ M ☐ F ☐ Married ☐ Widowed ☑ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ Years

ail nancy.omondi@kisanga.org Cell Phone #1 (443) 678-8692 Cell Phone #2 (_____) _____

ployer/School James Cummings Employer/School Phone (516) 312-1868

nployer/School Address 516 Gulf Road City North PB State FL Zip 33408

pouse or Parent's Name _____ Employer _____ Work Phone (____) _____

Who may we thank for referring you? Google

Person to Contact in case of Emergency? Elizabeth Omondi

HEALTH HISTORY

Reason for today's visit Physical test Date of Last Health Checkup 2020

Former Health Specialist LSU Health Center Date of Last Health X-Ray 2022 for Chest

Address _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child will ever have a change in health

I certify that I, and/or my dependent(s), have insurance coverage with N/A and assign directly to Name of Insurance Company(ies)

Dr. N/A all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chargers whether or not paid by insurance. I authorize the use of my signature on all insurance submissions

The above-name dentist may use my health care information and may disclosed such information to the above name insurance company(ies) and their agents put a purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. this consent will end when the current treatment plan is completed for one year from the date signed below.

Signature of Patient, Guardian or Personal Representative 03/24/2022 Date

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Parent

Payment is due in full at the time of treatment unless prior arrangements have been approved.

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