KCHC
Kenosha Community Health Center, Inc.

Medical: 4536 22nd Avenue Kenosha, WI 53140
Phone: 262-656-0044 Fax: 262-653-2218

Dental: 6226 14th Avenue Kenosha, WI 53143
Phone: 262-656-0044 Fax: 262-925-1680

Name: _____ DOB: _____ Phone: _____

DENTAL CLINIC MEDICAL HISTORY

Are you presently being treated by a physician? No_____ Yes _____ If yes, please list:

Reason _____ Date last seen _____

Physician Name _____ Physician Phone_____

List **ALL** medications and dosages (prescription, vitamins, herbs, and over-the-counter medications) _____

_____

_____

_____

Are you aware of any allergies to any of the following:

Penicillin	Y	N	Dental Anesthetic	Y	N	Aspirin	Y	N
Amoxicillin	Y	N	Sulfa	Y	N	Augmentin	Y	N
Erythromycin	Y	N	Codeine	Y	N	Latex	Y	N

Mammograms are easy and save lives.

We will help you with every step of the process from insurance, appointment, and follow up. Just ask!

Any other allergies/drug allergies we should be aware of: _____

Have you ever had any of the following medical problems?

Asthma	Y	N	Heart Murmur	Y	N	Psychiatric Problems	Y	N
Bleeding Problems	Y	N	Pacemaker	Y	N	Sickle Cell Anemia	Y	N
Blood Disorders	Y	N	Are You Pregnant?	Y	N	Stroke	Y	N
Blood Transfusions	Y	N	Hearing Loss/Impairment	Y	N	Shortness of Breath	Y	N
Cancer	Y	N	High Blood Pressure	Y	N	Pain in Chest Upon Exertion	Y	N
Diabetes	Y	N	Hepatitis	Y	N	Rheumatic Fever	Y	N
Epilepsy	Y	N	HIV/AIDS	Y	N	Tuberculosis	Y	N
Fainting Spells	Y	N	Artificial Joints	Y	N	Thyroid Problems	Y	N
Heart Condition	Y	N	Joint Disease	Y	N	Radiation Therapy	Y	N
Heart Valve Problems	Y	N	Kidney Disease	Y	N	Drug Addiction	Y	N
			Liver Disease	Y	N	Alcoholism	Y	N

Do you smoke or use other tobacco products? Yes ___ No ___

If so, how many cigarettes per day? _____ Number of years smoking _____

Are you interested in quitting? Yes ___ No ___

Please explain all "Yes" answers and list any medical conditions not listed above:

_____

STAFF USE ONLY:

WI QUIT LINE FORM FAXED? Yes___ No___

MEDICAL ALERT:

I have answered all the questions correctly to the best of my knowledge.

_____ _____ _____ _____

Patient Signature Date Physician Signature Date

_____ _____ Medical Changes _____

Date Patient Signature _____

_____ _____

Physician/Hyg. Signature

_____ _____ Medical Changes _____

Date Patient Signature _____

_____ _____

Physician/Hyg. Signature

_____ _____ Medical Changes _____

Date Patient Signature _____

_____ _____

Physician/Hyg. Signature