HEALTH CARE FOR THE HOMELESS, INC. ◆ 111 PARK AVENUE ◆ BALTIMORE, MD 21202 ◆ (410) 837-5533

HEALTH HISTORY FOR DENTAL REFERRALS

CLIENT NAME: _____ HCH#: _____

PROVIDER: _____ DATE: _____

HAS CLIENT HAD ANY OF THE FOLLOWING? INDICATE WITH A CHECK MARK (✓) OR X.
(EXPLAIN TREATMENT FOR ANY CONDITIONS PRESENT).

_____HEART PROBLEM
_____HEART MURMUR. IF YES, WAS CLIENT PROVIDED WITH SBE PROPHYLAXIS? _____
_____HIGH BLOOD PRESSURE
_____FAINTING OR DIZZINESS
_____CIRCULATORY PROBLEMS
_____ASTHMA
_____COPD OR OTHER PULMONARY CONDITION
_____ KIDNEY DISEASE
_____DIABETES
_____ARTHRITIS
_____EPILEPSY OR SEIZURES
_____SPEECH PROBLEMS
_____VISION OR EYE PROBLEMS
_____DEAFNESS OR HEARING PROBLEMS
_____USES WHEELCHAIR OR CRUTCHES
_____NEEDS ASSISTANCE TO WALK
_____SINUS PROBLEMS
_____PREGNANCY
_____SICKLE CELL DISEASE
_____EXCESSIVE BLEEDING

_____ HEPATITIS SIGNIFICANT BLOOD WORK RESULTS _____

_____ HIV IF NO, DATE OF LAST TEST _____
RISK FACTORS FOR HIV _____
(IF HIV+, SEND COPY OF CBC, CD4, CHEM, PT/PTT WITHIN PAST MONTH. REFER TO HIV CLINIC)

_____TUBERCULOS DATE OF LAST TB TEST OR CXR _____

_____SEXUALLY TRANSMITTED DISEASE

_____ALLERGY TO MEDICATION _____ALLERGY TO FOOD _____ALLERGY TO NOVACAINE OR NUMBING AGENT

PLEASE NOTE ANY ANTIBIOTIC AND/OR ANALGESIA PROVIDED TO CLIENT:

I AUTHORIZE RELEASE OF THE ABOVE INFORMATION TO THE DENTAL CLINIC. _____
(CLIENT SIGNATURE)