Maple Street Clinic
109 E. Maple
Gillespie, IL 62033
217-839-1526 – Medical/Behavioral
217-839-4110 – Dental

Morgan Street Clinic
1115 Morgan Street
Carlinville, IL 62626
217-854-3692 – Medical/Behavioral
217-854-6823 – Dental

MAPLE/MORGAN STREET MEDICAL CLINIC/MACOUPIN COUNTY PUBLIC HEALTH CLINIC SITE

Last Name:______________________________ **First Name**:________________________________ **MI**: ______ **Today's Date**: ________________

Birth Date: _____________ **Sex**: M / F / FTM / MTF **Sexual Orientation**: Lesbian/Gay Straight Bisexual Something Else Choose not to disclose

If the patient is a minor, please provide the parent's/guardian's name: ____

MEDICAL HISTORY

Do you have a medical doctor? YES NO

Medical doctor's name: ____ **Phone Number:** ____________________________

Please list all the medication you are currently taking including dose and directions:

_________________________________ _______________________________ _______________________________

_________________________________ _______________________________ _______________________________

_________________________________ _______________________________ _______________________________

Have you ever taken or are you currently taking Bisphosphonate drug such as Zometa, Fosamax, Actonel, Boniva, or Aredia?

Y N If yes, which drug(s)? ____

Y	N	High Blood Pressure	Y	N	Herpes/Fever Blisters	Y	N	Epilepsy/Seizures
Y	N	Low Blood Pressure	Y	N	HIV+/AIDS	Y	N	Migraines/Headaches
Y	N	Pacemaker	Y	N	Hepatitis	Y	N	Fainting/Dizzy spells
Y	N	Mitral Valve Prolapse	Y	N	Liver Disease	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Kidney Problems	Y	N	Psychiatric Conditions
Y	N	Heart Surgery	Y	N	Diabetes	Y	N	Difficulty Breathing
Y	N	Heart Murmur	Y	N	Ulcers/Colitis	Y	N	Coronary Artery Disease
Y	N	Congenital Heart Defect	Y	N	Arthritis	Y	N	Asthma
Y	N	Anemia	Y	N	Artificial Joints/Valves	Y	N	Emphysema
Y	N	Bleeding Problems	Y	N	Cancer	Y	N	Stroke
Y	N	Bruise Easily	Y	N	Chemotherapy	Other Conditions not listed:		
Y	N	Sickle Cell Anemia	Y	N	Radiation Treatment	______________________________		
Y	N	Hemophilia	Y	N	Hospitalized for any reason	______________________________		

Y N **Tobacco use?** If yes, how many packs a day? ___________ How many years? ___________

Y N **Alcohol use?** If yes, how many drinks per week? ________

Y N **Drug abuse?** If yes, what drugs? ____

FOR WOMEN

Y N Are you pregnant? If yes, when is your due date? ___________

Y N Are you nursing?

ALLERGIES

Are you allergic to any of the following:

Y	N	Dental Anesthetic	Y	N	Penicillin	Y	N	Codeine
Y	N	Aspirin	Y	N	Amoxicillin	Y	N	Erythromycin
Y	N	Latex	Y	N	Metals			

Other: ____

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DENTAL HISTORY

When was your last dental exam? ______________________________

What is the reason for your visit today? ____

If you have dentures when/where were they placed? ____

PATIENT AUTHORIZATION/CONSENT TO TREATMENT

The information I have provided is correct to the best of my knowledge. I assume any risk to myself or my dependent and understand that I will ask if there are any questions regarding diagnosis or treatment. I understand it is my responsibility to inform this office of any changes in my/my dependent's medical status and/or medications being taken. I authorize treatment, the use of nitrous oxide, anesthesia, oral sedation and/or other medications necessary to be rendered by the staff. I understand that I will be expected to update the information on this history form on an annual basis.

Patient/Parent's Signature:____ **Date:** _______________________

Provider's Signature: ____ **Date:** _______________________

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