Department of Dental Hygiene
MEDICAL HISTORY

Date:

Personal Information

Patient Name:			Home #
Street Address:			Work #
City, State, & Zip Code:			Cell #
Date of Birth:	Height:	Weight:	Gender:
Email Address:			Marital Status (circle): M S D W

Ethnicity (circle) American Indian or Alaska Native Asian Black or African American Hispanic or Latino Native Hawaiian or Other Pacific Islander White

Emergency Contact Information

Contact Name:	Home #
Relationship:	Cell #

If you are completing this form for the patient, what is your relationship to the patient?

Please answer all the questions. All information provided by you is for our records and will be confidential

General Health Questions

Are you in good health?	O Yes	O No	
When was your last physical exam?			

If YES to any of the following questions, please explain further.

Are you currently under a physician's care?	O Yes	O No	*If yes:*
Have you ever been hospitalized or has a serious illness?	O Yes	O No	*If yes:*
Have you ever had any excessive bleeding?	O Yes	O No	*If yes:*
Are you in recovery status from substance abuse?	O Yes	O No	*If yes:*
Have you ever taken Fosamax, Boniva, Actonel, or any other medications Bisphosphonates?	O Yes	O No	*If yes:*

Physician or Hospital Information *Please provide you PHYSICIAN and/or hospital information*

Physician's Name:	Street Address:
Phone Number:	City, State, & Zip Code:

Current and Past Health Conditions *Do you have/had any of the following conditions?*

Condition			Condition			Condition			Condition		
Abnormal Bleeding	O Yes	O No	Eating Disorder	O Yes	O No	High Cholesterol	O Yes	O No	Rheumatic Fever	O Yes	O No
Anemia	O Yes	O No	Emphysema	O Yes	O No	HIV/AIDS	O Yes	O No	Scarlet Fever	O Yes	O No
Angina	O Yes	O No	Epilepsy or Seizures	O Yes	O No	Hypoglycemia	O Yes	O No	Sexually Transmitted Disease	O Yes	O No
Arthritis	O Yes	O No	Excessive Thirst	O Yes	O No	Infective Endocarditis	O Yes	O No			
Artificial Joints	O Yes	O No	Fainting Spells/ Dizziness	O Yes	O No	Kidney Problems	O Yes	O No	Shingles	O Yes	O No
Artificial Heart Valve	O Yes	O No				Liver Disease	O Yes	O No	Sickle Cell Trait Disease	O Yes	O No
	Yes	No	Frequent Headaches	O Yes	O No				Sinus Problems	O Yes	O No
Asthma	O Yes	O No	Glaucoma	O Yes	O No	Low Blood Pressure	O Yes	O No	Steroid Therapy	O Yes	O No
Blood Transfusion	O Yes	O No	Hearth Attack/Failure	O Yes	O No	Lupus	O Yes	O No	Stroke	O Yes	O No
Cancer	O Yes	O No	Hearth Murmur	O Yes	O No	Mitral Valve Prolapse	O Yes	O No	Substance Abuse	O Yes	O No
Chemotherapy	O Yes	O No	Heart Surgery	O Yes	O No	Organ Transplant	O Yes	O No	Swollen Ankles	O Yes	O No
Chest Pain	O Yes	O No	Hemophilia	O Yes	O No	Osteoporosis	O Yes	O No	Thyroid Problems	O Yes	O No
Cold Sores/Fever/Blisters	O Yes	O No	Hepatitis A	O Yes	O No	Pacemaker	O Yes	O No	Tonsillitis	O Yes	O No
Congenital Heart Defects	O Yes	O No	Hepatitis B or C	O Yes	O No	Persistent Cough	O Yes	O No	Tuberculosis (TB)	O Yes	O No
Diabetes	O Yes	O No	Herpes	O Yes	O No	Psychiatric Care	O Yes	O No	Ulcers	O Yes	O No
Difficulty Breathing	O Yes	O No	High Blood Pressure	O Yes	O No	Radiation Treatment	O Yes	O No	Weight gain/loss >10 lbs.	O Yes	O No

Have you ever had another condition not listed above?	O Yes O No	*If yes:*

Additional Health Questions

Do you have persistent swollen glands in the neck?	O Yes	O No	Do you use more than 2 pillows to sleep?	O Yes	O No
Do you have chest pain upon exertion or when exercising?	O Yes	O No	*If yes, why?*		
Are you short of breath after mild exercise or when lying down?	O Yes	O No	Are you on special diet?	O Yes	O No
Do you wake up from sleep short of breath?	O Yes	O No	*If yes, why?*		

Allergies

Acetaminophen	O Yes	O No	Codeine	O Yes	O No	Jewelry/Metals	O Yes	O No	Sulfa Drugs	O Yes	O No
Amoxicillin	O Yes	O No	Dental Anesthetics	O Yes	O No	Latex	O Yes	O No	Tetracycline	O Yes	O No
Aspirin	O Yes	O No	Erythromycin	O Yes	O No	Penicillin	O Yes	O No			
Barbiturates	O Yes	O No	Ibuprofen	O Yes	O No	Sedatives	O Yes	O No			

Do you have another allergy not listed above? O Yes O No *If yes:*

Medications *Are you taking any of the following?*

Antibiotics	O Yes	O No	Blood Thinners	O Yes	O No	Insulin/Diabetes Medicine	O Yes	O No	Steroids/Cortisone	O Yes	O No
Antihistamines	O Yes	O No	Blood Pressure Medicine	O Yes	O No	Nitroglycerin	O Yes	O No	Thyroid Medicine	O Yes	O No
Aspirin	O Yes	O No	Digitalis/Heart Medicine	O Yes	O No	Over-the-Counte Medicine	O Yes	O No	Vitamins and/or Minerals	O Yes	O No
Birth Control Medication	O Yes	O No	Herbal Supplements	O Yes	O No	Sedatives	O Yes	O No			

If YES to taking any of the above, please list the name(s) of the medication(s)

Other Personal History

Are you hearing impaired?	O Yes	O No	Do you drink alcohol?	O Yes	O No	*If yes, how often?*
Are you wearing contact lenses?	O Yes	O No	Do you use tobacco products?	O Yes	O No	*If yes, how often?*
Are you employed in a situation which exposes you regularly to x-rays or ionizing radiation?	O Yes	O No	Are you interested in quitting tobacco?	O Yes	O No	
**WOMEN only* : Are you… currently pregnant?	O Yes	O No	trying to get pregnant?	O Yes	O No	
currently nursing?	O Yes	O No	using contraceptives?	O Yes	O No	

Dentist Information *Please provide you DENTIST and/or dental care facility information*

Physician's Name:	Street Address:
Phone Number:	City, State, & Zip Code:

Dental History

Reason for visit:	Do you require antibiotics before dental treatment? O Yes O No
When was you last dental appointment?	Have you had a bad experience in the dental office? O Yes O No
Rate your current dental health: O Good O Fair O Poor	Does dental treatment make you nervous? O Yes O No
Are you currently under the care of a dentist? O Yes O No	If yes, circle to what extend: O Slightly O Moderate O Extremely

Oral Hygiene Information

Do you use the following?				
Toothbrush	O Yes	O No	How often do you brush your teeth?	
Toothpaste	O Yes	O No	How often do you floss your teeth?	
Dental Floss	O Yes	O No	What type of toothpaste do you use?	
Mouth rinse	O Yes	O No	What type of toothbrush do you use? O Soft O Medium O Hard	
Fluoride	O Yes	O No	Are you wearing any dental appliances?	O Yes O No
Other Dental Products	O Yes	O No		

Do you have any of these oral habits?		
Thumb sucking:	O Yes	O No
Nail biting:	O Yes	O No
Clenching:	O Yes	O No
Grinding:	O Yes	O No

Risk Factors

Social economic Status (*please circle*)
Middle High

Education N/A High School Bachelors Graduate Studies

Any Nutritional Concerns?	O Yes	O No
Any Aging Concerns?	O Yes	O No
Any Immune/Systemic Concerns?	O Yes	O No

If YES, please explain:

Current & Past Dental Conditions *Do you have or have had any of the following?*

Abscess (oral infection)	O Yes	O No	Difficulty opening or Closing jaw	O Yes	O No	Jaw Surgery	O Yes	O No
Bad breath/unpleasant taste	O Yes	O No	Gums swollen or tender	O Yes	O No	Loose teeth or broken fillings	O Yes	O No
Blisters on lips or mouth	O Yes	O No	Endodontic (root carnal) treatment	O Yes	O No	Orthodontic treatment	O Yes	O No
Bleeding, sore gums	O Yes	O No	Extractions	O Yes	O No	Periodontal (gum) treatment	O Yes	O No
Clicking/popping jaw	O Yes	O No				Sensitivity to cold,hot,sweets	O Yes	O No
Dental Implants	O Yes	O No						

I certify, to the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes, in my health, or medications, I will inform this dental health care provider prior to or at the next appointment without fail.

Signature of Patient, Parent or Guardian:	Date
Student Clinician's Initials	Date