PT ID#

*Office use only*

# DENTAL/MEDICAL HISTORY FORM

SLCC has written policies on this clipboard to protect your privacy. Please read them and if you have any questions please ask. The Dental/Medical History Form should be answered completely and as accurately as possible. The information will allow us to provide appropriate care for you. Thank you for being a patient in our student dental hygiene clinic.

*PLEASE FILL OUT THIS FORM COMPLETELY*

Last Name: _____First name: _____Middle Initial: _____ Male ☐ Female ☐

Street Address: _____City_____State_____ Zip: _____ Date of Birth: _____
m/d/yr

Cell Phone: _____Alternate Phone: _____email: _____

How do you prefer we contact you? _____ Occupation: _____

Emergency contact: _____ Relationship: _____Phone: _____

Dentist Name: _____ City: _____State: _____ Phone: _____

## Dental History

| | Question | Yes | No | | Question | Yes | No |
|---|---|---|---|---|---|---|---|
| A. | Do your gums bleed when you brush or floss? | | | K. | Do you have any sores or ulcers in your mouth? | | |
| B. | Are your teeth sensitive to hot, cold, sweets, or pressure? | | | L. | Do you participate in energetic sports or activities? | | |
| C. | Does food or floss catch between your teeth? | | | M. | Do you experience frequent ulcers in your mouth? | | |
| D. | Is your mouth often dry? | | | N. | Do you grind your teeth? | | |
| E. | Have you had periodontal (gum) treatment? | | | O. | Do you wear dentures or partial dentures? | | |
| F. | Have you had orthodontic treatment (braces)? | | | P. | Is your home water fluoridated? | | |
| G. | Have you had serious injury to your head or mouth? | | | Q | Do you frequently drink bottled water? | | |
| H. | Do you have clicking, Popping, or other discomfort in your jaw? | | | R. | Date of your last dental Exam? | / / | |
| I. | Have you had any problems related to dental treatment? | | | S. | Date of your last dental radiographs (x-rays) | / / | |
| J. | Are you currently experiencing dental pain or discomfort? | | | T. | How do you feel about your smile? | | |

m/d/yr

What is the reason for your visit today? _____

## Medical History

| | Question | Yes | No | If Yes, please explain |
|---|---|---|---|---|
| A. | Are you under a physician's care now? | | | |
| B. | Have you ever been hospitalized or had a major operation? | | | |
| C | Have you ever had a serious head or neck injury? | | | |
| D. | Are you taking any medications, pills, or drugs? | | | |
| E. | Do you take, or have you taken, Phen-Fen or Redux? | | | |
| F. | Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? | | | |
| G. | Are you on a special diet? | | | |
| H. | Do you use tobacco? | | | |
| I. | Do you use controlled substances? | | | |

## Medications

Please list any/all prescription and over-the-counter medicines that you are currently taking. Include vitamins, natural medicines, herbal supplements or remedies. Please include dosages and frequency of use.

| Prescription | | Over-the-counter | |
|---|---|---|---|
| Name of medication | Dose | Product name | Frequency of use |
| | | | |
| | | | |
| | | | |
| | | | |

Do you have, or have you had any of the following?

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AIDS/HIV positive | | | Cortisone medicine | | | Hemophilia | | | Radiation treatment | | |
| Alzheimer's disease | | | Diabetes | | | Hepatitis A | | | Recent weight loss | | |
| Anaphylaxis | | | Drug addiction | | | Hepatitis B or C | | | Renal dialysis | | |
| Anemia | | | Easily winded | | | Herpes | | | Rheumatic fever | | |
| Angina | | | Emphysema | | | High blood pressure | | | Rheumatism | | |
| Arthritis/Gout | | | Epilepsy or seizures | | | High cholesterol | | | Scarlet fever | | |
| Artificial heart valve | | | Excessive bleeding | | | Hives or rash | | | Shingles | | |
| Artificial joint | | | Excessive thirst | | | Hypoglycemia | | | Sickle cell disease | | |
| Asthma | | | Fainting or dizziness | | | Irregular heartbeat | | | Sinus trouble | | |
| Blood disease | | | Frequent cough | | | Kidney problems | | | Spinal bifida | | |
| Blood transfusion | | | Frequent diarrhea | | | Leukemia | | | Stomach/Intestinal disease | | |
| Breathing problems | | | Frequent headaches | | | Liver disease | | | Stroke | | |
| Bruise easily | | | Genital herpes | | | Low blood pressure | | | Swelling of limbs | | |
| Cancer | | | Glaucoma | | | Lung disease | | | Thyroid disease | | |
| Chemotherapy | | | Hay fever | | | Mitral valve prolapse | | | Tonsillitis | | |
| Chest pains | | | Heart attach/Failure | | | Osteoporosis | | | Tuberculosis | | |
| Cold sores/Fever blisters | | | Heart murmur | | | Pain in jaw joints | | | Tumors or growths | | |
| Congenital heart disorder | | | Heart pacemaker | | | Parathyroid disease | | | Ulcers | | |
| Convulsions | | | Heart trouble/Disease | | | Psychiatric care | | | Venereal disease | | |
| Have you ever had any serious illness, or body piercings not listed above? | | | If Yes, Please explain:_____ _____ _____ | | | | | | Yellow Jaundice | | |

Additional questions for women.

| Question | Yes | No |
|---|---|---|
| Are you pregnant or trying to get pregnant? | | |
| Are you taking oral contraceptives? | | |
| Are you nursing? | | |

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other; please explain: _____

Physicians name: _____City: _____State: _____ Phone: _____

I understand the importance of complete and truthful medical and dental information and that incorrect information could pose a serious threat to my health. To the best of my knowledge the answers to the preceding questions are true and correct. I will not hold Salt Lake community College (SLCC) or any person who provides dental Hygiene or dental services responsible for any actions that they take or do not take because of any errors or omissions that I may have made in the completion of this form. I consent to the release of medical/dental information to my dentist, physician, or other healthcare professional if requested.

Further, if I ever have any change in my health, or if my medications change, I will inform my student dental hygienist or a SLCC faculty member at my next appointment. I hereby grant permission to be treated by students and faculty of SLCC.

_____ _____

*Signature of Patient/Legal Guardian* *Date*

_____ _____

*Signature of Student/Number* *Date*

_____ _____

*Signature of Clinical Instructor/Number* *Date*

*Note: Your signature below verifies that any necessary changes to the history for subsequent appointments have been noted and dated on the form. A new dental/medical history form must be completed every three years.*

| | Date | Yes | No | Patient signature | Patient Vitals | | | Student | Instructor |
|---|---|---|---|---|---|---|---|---|---|
| a | / / | | | | BP: | P: | R: | | |
| b | / / | | | | BP: | P: | R: | | |
| c | / / | | | | BP: | P: | R: | | |
| d | / / | | | | BP: | P: | R: | | |
| e | / / | | | | BP: | P: | R: | | |
| f | / / | | | | BP: | P: | R: | | |
| g | / / | | | | BP: | P: | R: | | |
| h | / / | | | | BP: | P: | R: | | |