CHABOT COLLEGE – DENTAL HYGIENE PROGRAM

MEDICAL/DENTAL HISTORY

Patient's Name: _____ ☐ New Patient ☐ Returning Patient
(Last) (First)

Sex: ☐ Male ☐ Female Height: _____ Weight: _____ Date of Birth: _____

Please Answer All Questions

Medical History

Your Primary Physician's Name: _____ Date of last physical exam: _____

Address: _____ City: _____ Zip: _____ Phone: (_____) _____

Is more than one doctor treating you? ☐ Yes ☐ No For What? _____

Doctor's Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____) _____

Please list all medications you are currently taking: _____

Have you ever had an adverse reaction to any of the following?
☐ Penicillin or other antibiotics ☐ Aspirin, Codeine or other pain medications ☐ Novocain, Lidocaine, or other anesthetics
Have you been hospitalized, had a serious illness, or had any kind of surgery in the past 5 years? ☐ Yes ☐ No If yes, what for? _____
(Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐Yes ☐ No Taking oral contraception? ☐ Yes ☐ No)

Check (✓) any of the following that apply to you:

☐ AIDS
☐ Alcoholism
☐ Allergies
☐ Anemia
☐ Angina/Chest Pain
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
When placed? _____
☐ Asthma
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Blood transfusions
☐ Blurred vision
☐ Cancer
☐ Chemical Dependency
☐ Chemotherapy
☐ Circulatory Problems
☐ Congenital Heart Defect
☐ Contact lenses
☐ Diabetes
☐ Diabetes
☐ Diarrhea, constipation, blood in stool
☐ Difficulty swallowing
☐ Difficulty urinating, blood in urine
☐ Dry mouth
☐ Emphysema
☐ Epilepsy
☐ Excessive thirst/urination
☐ Fainting
☐ Frequent vomiting, nausea
☐ Frequent urination
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
Describe _____
☐ Hemophilia
☐ Hepatitis
☐ Hernia Repair
☐ Herpes
☐ High Blood Pressure
☐ HIV positive
☐ Jaundice
☐ Joint pain, stiffness
☐ Joint Surgery
When? _____
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Nervous Problems
☐ Pacemaker
☐ Persistent cough, coughing up blood
☐ Prolonged Bleeding
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recent weight loss, fever, night sweats
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sexually Transmitted Diseases
☐ Shortness of breath
☐ Skin Rashes
☐ Stroke
☐ Swelling of feet or ankles
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors
☐ Ulcer
☐ Other
Describe _____

TURN FORM OVER AND ANSWER QUESTIONS ON THE BACK

Please do not write below this space

DATE	ASA:	

Patient's Name: _____ Occupation: _____
(Last) (First)

Address: _____ City: _____ Zip: _____

Home Phone: (____) _____ Business Phone: (____) _____ Cell: (____) _____

DENTAL AND SOCIAL HISTORY

Your Dentist's Name: _____ Date of last exam: _____

Address: _____ City: _____ Zip: _____ Phone: (____) _____

Date of last dental X-rays: _____ Type of survey?: ☐ Bitewings ☐ Full Mouth X-ray ☐ Panographic X-ray

How often do you brush? _____ How often do you floss? _____ Date of last teeth cleaning: _____

Have you had problems with prior dental treatment? ☐ Yes ☐ No Have you had problems with dental anesthesia? ☐ Yes ☐ No

Reason for today's visit : _____

Please check (✓) any of the following conditions that apply to you:

- ☐ Bad breath
- ☐ Bleeding Gums
- ☐ Clicking or popping jaw
- ☐ Cold sores
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Jaw Pain
- ☐ Loose teeth or broken fillings
- ☐ Oral Surgery
- ☐ Orthodontics
- ☐ Periodontal/gum surgery
- ☐ Root canal
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growth in your mouth
- ☐ Teeth Extracted

List any vitamins, minerals or herbal products that you take: _____

Have you ever taken any of these diet medications? ☐ Dexfenfluramine ☐ Fen-phen ☐ Pondimin ☐ Redux

Do you smoke/chew tobacco products? ☐ Yes ☐ No What kind? _____ How often? _____

Do you use recreational drugs? ☐ Yes ☐ No What kind? _____ How often? _____

Do you drink alcohol? ☐ Yes ☐ No What kind? _____ How often? _____

Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the student hygienist if I, or my minor child, ever have a change in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Respresentative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

In case of emergency notify: _____ Relationship: _____

Address: _____ City: _____ Zip: _____ Phone: (___) _____

Please do not write below this space

DATE	

Baseline Evaluation	Date	BP	Pulse	R

Any contraindications to local anesthetic? ☐ Yes ☐ No If yes, explain: _____

Consultation Needed? ☐ Yes ☐ No Clear for Assignment? ☐ Yes ☐ No

Student: _____ #____ Dentist: _____ #_____ Date: _____