NHTI – CONCORD'S COMMUNITY COLLEGE
CLIENT MEDICAL/DENTAL HISTORY FORM

All information provided is considered confidential and vital for dental care at NHTI - Concord's Community College.

Client Name: ____ **Birth Date**: __________
Last First MI

Address: ________________________ ________________ ________ ________
Street City State Zip Code

________________________ Email Address: ________________________________
Occupation

Phone (Home):__________ **(Work):** __________ Ext_____ **(Cell):** __________

________________ ________________ ________________ ________________
Emergency Contact **Relationship** **Home Phone** **Business/Cell Phone**

DENTAL INFORMATION

Do you wear dentures or partials?	YES	NO	Have you had any oral surgery /implants?	YES	NO
Have you had periodontal treatment?	YES	NO	Any serious injury to your head or mouth?	YES	NO
Have you had orthodontic treatment?	YES	NO	Are you experiencing any dental pain today?	YES	NO
Do you have a TMJ Disorder?	YES	NO	Fluoridated water/Supplement	YES	NO
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?				YES	NO

Dentist Name: ________________________________ **Phone Number:** ______________
Address:____**ZIP Code:** __________
Date of last dental exam: ______________ **Date of last cleaning:** ______________
Date of last bitewing radiographs: __________ **Date of last full mouth series of radiographs:** _______

MEDICAL INFORMATION

Physician's Name:________________________ Phone: (   ) ____________________

Address: ________________________ City/State/Zip ____________________

Are you under the care of a physician? YES NO Date of last physical exam: __________

Have you had a serious illness, operation or been hospitalized in the past 5 years? YES NO

Has there been any change in your general health within the past year or are you being treated for a condition now? YES NO

If yes, explain: ____

*Please circle if you are allergic to the following:

Local anesthetics Aspirin Penicillin or other antibiotics Latex Foods
Barbiturates, Sedatives Sulfa drug Codeine or other narcotics Other: __________
Describe Reaction: ____

PRESCRIPTION or NON PRESCRIPTION or HERBAL MEDICATIONS
List all medications and herbal supplements/remedies that you are currently taking.

NAME DOSE	NAME DOSE	NAME DOSE

Are you taking or have taken any diet drugs such as Pondimin, Redux or Phen-fen? YES NO
Are you taking or scheduled to begin taking either of the medications Fosamax or Actonel? YES NO
Since 2001, were you treated or are you scheduled to begin treatment with the intravenous bisphosphates (Aredia or Zometa) for bone pain, hypocalcaemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? YES NO

Please circle Yes or No (Y or N) for any illnesses that you CURRENTY HAVE OR HAVE HAD IN THE PAST.

HEART/BLOOD DISORDERS		
*Artificial Heart Valves	Y	N
*Congenital Heart Defects	Y	N
Heart Murmurs	Y	N
*Angina	Y	N
Congestive Heart Failure	Y	N
*Heart Surgery	Y	N
*Heart Attack	Y	N
*Prosthetic Heart Valve	Y	N
Pacemaker/Defib	Y	N
*Bacterial Endocarditis	Y	N
Coronary Artery Disease	Y	N
*High Blood Pressure	Y	N
Abnormal Bleeding	Y	N
Hemophilia	Y	N
Anemia	Y	N
OTHER:		
RESPIRATORY/LUNG CONDITIONS		
*Asthma	Y	N
*Emphysema/COPD	Y	N
Bronchitis	Y	N
**Do you have any of the following diseases or problems? IF YES, STOP , PLEASE SEE BELOW		
History of Tuberculosis?	Y	N
*Active Tuberculosis?	Y	N
Persistent cough greater then a 3 week duration?	Y	N
Cough that produces blood?	Y	N
Been exposed to anyone with Tuberculosis?	Y	N

OTHER CONDITIONS		
*Kidney Problems/Dialysis	Y	N
Liver Disease	Y	N
*Artificial Joints	Y	N
Type:		
Cancer/Chemotherapy/Radiation	Y	N
Persistent Swollen Glands	Y	N
Osteoporosis	Y	N
Chronic Pain	Y	N
Pregnancy/Nursing	Y	N
Due Date:		
OTHER:		
INFECTIOUS DISEASES		
AIDS/HIV	Y	N
Hepatitis	Y	N
Sexually transmitted disease	Y	N
OTHER:		
GASTROINTESTINAL DISORDERS		
G.E. Reflux/Heartburn	Y	N
Ulcers/Gastritis	Y	N
Eating Disorder	Y	N
Inflammatory Bowel Disease	Y	N
NEUROLOGICAL DISORDERS		
Epilepsy	Y	N
*Stroke	Y	N
Migraine	Y	N
OTHER:		

IMMUNE SYSTEM DISORDERS		
Systemic Lupus	Y	N
Rheumatoid Arthritis	Y	N
Sjogren's Syndrome	Y	N
Allergies	Y	N
OTHER:		
BEHAVIORAL CONDITIONS/HABITS		
Mental Health Disorder	Y	N
Anxiety/Panic Attacks	Y	N
Controlled Substance Use	Y	N
What?		
Alcohol Use	Y	N
Amount per week:		
Tobacco Use	Y	N
Type:		
Amount per day:		
Interested in Stopping	Y	N
OTHER:		
HORMONAL OR METABOLIC DISORDERS		
Diabetes, Type I or II	Y	N
Thyroid Problem	Y	N
OTHER:		

**If you have answered yes to any of these 4 questions above, please stop and return this form to the receptionist.

Additional Comments:

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Do you have any disease, condition or problem not listed above that you think we should know about?

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To the best of my knowledge, the above information is complete and correct.

____ **Date:** ____________________

Signature **Print Name**

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

Name: ______________________ **Relationship**______________________

Revised 9/10/2010

PROGRESS NOTES **CLIENT:** ______________________________

DATE	NARRATIVE	STUDENT	FACULTY

PROGRESS NOTES **CLIENT:** ______________________________

DATE	NARRATIVE	STUDENT	FACULTY