**NHTI – CONCORD’S COMMUNITY COLLEGE**

**PATIENT MEDICAL/DENTAL HISTORY FORM**

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

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| **Patient’s Legal Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last First MI  **Preferred Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  Street City State Zip Code  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Occupation  **Phone (Home)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Work):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext\_\_\_\_\_\_\_ **(Cell):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Emergency Contact Relationship Home Phone Business/Cell Phone** |

**Dentist’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DENTAL INFORMATION:**

**Date of last dental exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental cleaning: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of last bitewing radiographs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last full mouth series of radiographs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- | --- | --- |
| 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 |

**Please list any medications that you are taking now. Include non-prescription medications, vitamins or supplements:**

**NAME OF MEDICATION DOSE (include strength & number of pills per day REASON FOR TAKING**

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**\*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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you taking or have you taken any diet drugs, such as Pondimin, Redux or Phen-fen? YES NO**

**Are you taking or scheduled to begin any Bisphosphonate therapy such as Fosamax or Actonel? YES NO**

**Have you ever been treated or are you scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa)**

**for bone pain, hypocalcaemia or skeletal complications (osteoporosis) resulting from Paget’s disease, multiple**

**myeloma or metastatic cancer? YES NO**

**Have you ever taken oral Bisphosphonate therapy for 3 years or more? YES NO**

**MEDICAL INFORMATION**

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

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| **HEART/BLOOD DISORDERS** | | | **OTHER CONDITIONS** | | | | **IMMUNE SYSTEM DISORDERS** | | | | |
| \*Artificial Heart Valves | **Y** | **N** | \*Kidney Problems/Dialysis | | **Y** | **N** | Systemic Lupus | | **Y** | **N** | |
| \*Congenital Heart Defects | **Y** | **N** | \*Liver Disease | | **Y** | **N** | Rheumatoid Arthritis | | **Y** | **N** | |
| Heart Murmurs | **Y** | **N** | \*Artificial Joints | | **Y** | **N** | Sjogren’s Syndrome | | **Y** | **N** | |
| \*Angina | **Y** | **N** | Type: | | | | Allergies | | **Y** | **N** | |
| Congestive Heart Failure | **Y** | **N** | Cancer/Chemotherapy/Radiation | | **Y** | **N** | Myasthenia Gravis | | | | |
| \*Heart Surgery | **Y** | **N** | Persistent Swollen Glands | | **Y** | **N** | OTHER: | | | | |
| \*Heart Attack | **Y** | **N** | Osteoporosis | | **Y** | **N** |  | | | | |
| \*Prosthetic Heart Valve | **Y** | **N** | Chronic Pain | | **Y** | **N** | **BEHAVIORAL CONDITIONS** | | | | |
| Pacemaker/Defibrillator | **Y** | **N** | Pregnancy/Nursing | | **Y** | **N** | Anxiety/Panic Attacks | **Y** | | | **N** |
| \*Bacterial Endocarditis | **Y** | **N** | Due Date | | | | Eating Disorder | | **Y** | **N** | |
| Coronary Artery Disease | **Y** | **N** | Glaucoma | | **Y** | **N** |  | | | | |
| \*High Blood Pressure | Y | N | OTHER: | | | | **SUBSTANCE USE** | | **Y** | **N** | |
| Abnormal Bleeding | Y | N |  | | | | (circle all that apply/current/history) | | | | |
| Methemoglobinemia | Y | N | **INFECTIOUS DISEASES** | | | | crack; | | | | |
| Hemophilia | Y | N | AIDS/HIV | **Y** | | **N** | Cocaine; Crack; Methamphetamine; Amphetamines | | | | |
| Anemia | Y | N | Hepatitis | **Y** | | **N** | Amphetamines; Benzodiazepines; Heroin; Opioids; | | | | |
| OTHER: |  |  | Sexually Transmitted disease | **Y** | | **N** | Opioids; Hallucinogens; Inhalants; Ecstasy; | | | | |
|  |  |  | OTHER: | | | | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| **RESPIRATORY/LUNG CONDITIONS** | | |  | | | | Cannabis/Marijuana: | | | | |
| \*Asthma | **Y** | **N** | **GASTROINTESTINAL DISORDERS** | | | | Answer the following regarding cannabis: ccanniccibiscacannabisuse: | | | | |
| \*Emphysema/COPD | **Y** | **N** | G.E. Reflux/Heartburn | **Y** | | **N** | For what purpose do you use cannabis? | | | | |
| Bronchitis | **Y** | **N** | Ulcers/Gastritis | **Y** | | **N** | \_\_\_\_Medical \_\_\_\_ Recreational \_\_\_\_ Both | | | | |
|  |  |  | Inflammatory Bowel Disease | **Y** | | **N** | If medical, for what condition? | | | | |
| **\*\*Do you have any of the following diseases or problems**? **IF YES, STOP AND SEE RECEPTIONIST** | | | OTHER: | | | |  | | | | |
|  | | | | What type of delivery do you typically use? | | | | |
| History of Tuberculosis? | **Y** | **N** | **NEUROLOGICAL DISORDERS** | | | |  | | | | |
| \*Active Tuberculosis? | **Y** | **N** | Have you experienced any medical problems from | | | | |
| Persistent cough greater than a 3 week duration? | **Y** | **N** | Epilepsy | **Y** | | **N** | with your use? \_\_\_\_\_ Yes \_\_\_\_\_ No | | | | |
| Cough that produces blood? | **Y** | **N** | \*Stroke | **Y** | | **N** | When was your last dose and how much did you take? | | | | |
| Been exposed to anyone with Tuberculosis? | **Y** | **N** | Migraine | **Y** | | **N** | take? | | | | |
|  | | | OTHER: | | | | Are you experiencing any symptoms of marijuana | | | | |
|  | | |  | | | | marijuana use now? \_\_\_\_\_ Yes \_\_\_\_\_ No | | | | |
|  | | | **HORMONAL OR METABOLIC**  **DISORDERS** | | | | If yes, what type of symptoms are you having? | | | | |
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|  | | | Alcohol Use | | **Y** | **N** | |
|  | | | Diabetes, Type I or II | **Y** | | **N** | Amount per week: | | | | |
|  | | | Thyroid Problem | **Y** | | **N** | Tobacco//Vaping/Juuling/Hookah/ | | **Y** | **N** | |
|  | | | OTHER: | | | | Type: | | | | |
|  | | |  | | | | Amount per day: | | | | |
|  | | |  | | | | Interested in stopping any substance? | **Y** | | | **N** |
|  | | |  | | | | Please list substance you would like to stop: | | | | |
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**PATIENT MEDICAL/DENTAL HISTORY FORM –** Page 3

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| **Patient:** |  |
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| **Do you have any disease, condition or problem not listed above? If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | |

**Additional Comments:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature Print Name**

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| **If you are completing this form for another person, what is your name and relationship to the patient?**  **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Updated 6-7-21**

**(See reverse side for Progress Notes)**

**PROGRESS NOTES PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **DATE** | **NARRATIVE** | **STUDENT** | **FACULTY** |
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Rev. 12-6-21