**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.**

|  |
| --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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**

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

 **\*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.**

|  |  |  |
| --- | --- | --- |
| **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? |
|  |  |
|  | 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: |
|  |  |  |

**PATIENT MEDICAL/DENTAL HISTORY FORM –** Page 3

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

 **Additional Comments:**

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

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

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

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Updated 6-7-21**

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| **DATE** | **NARRATIVE** | **STUDENT** | **FACULTY** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Rev. 12-6-21