Time 3:07 PM KALAMAZOO VALLEY COMMUNITY COLLEGE Date 8/30/2019

Medical/Dental History revised 2019

Patient Name: Birth Date: Date Created:

PERSONAL INFORMATION:

Current Height: ☐ If yes

Current Weight: ☐ If yes

Gender:

☐ Male ☐ Female ☐ Prefer to self-describe ☐ Prefer not to say

Marital Status

☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Prefer not to say

Occupation: ☐ If yes

Are you completing this form for another person? If yes, what is your relationship to that person ◯ Yes ◯ No If yes

CRITICAL MEDICAL QUESTIONS:

Do you have any of the following diseases or problems:

Active Tuberculosis? ◯ Yes ◯ No

Been exposed to anyone with tuberculosis? ◯ Yes ◯ No

Persistent cough greater than a 3 week duration? ◯ Yes ◯ No

Had a stroke within the last 6 months? ◯ Yes ◯ No

Had a heart attack within the last 30 days? ◯ Yes ◯ No

Have an active cold sore on your lips or mouth? ◯ Yes ◯ No

IF YOU ANSWERED YES TO ANY OF THE ITEMS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST.

MEDICAL INFORMATION:

Are you under the care of a physician? ◯ Yes ◯ No If yes

Are you in good health? ◯ Yes ◯ No

Has there been any changes in your general health within the past year? ◯ Yes ◯ No If yes

Date of last physical exam ☐ If yes

Have you had a serious illness, operation or been hospitalized in the past 5 years? ◯ Yes ◯ No If yes

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ◯ Yes ◯ No If yes

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No

Do you use controlled substances (drugs)? ◯ Yes ◯ No If yes

Do you smoke, chew, or vape any substance? If yes, amount, type, and frequency ◯ Yes ◯ No If yes

Do you drink alcoholic beverages? If yes, amount and frequency ◯ Yes ◯ No If yes

ALLERGIES:

Are you allergic to or have you had a reaction to:

Animals	◯ Yes ◯ No	Food	◯ Yes ◯ No	Local anesthesia	◯ Yes ◯ No
Aspirin	◯ Yes ◯ No	Hayfever/seasonal	◯ Yes ◯ No	Metals	◯ Yes ◯ No
Barbiturates, sedatives, or sleeping pills	◯ Yes ◯ No	Iodine	◯ Yes ◯ No	Penicillin or other antibiotics	◯ Yes ◯ No
Codeine or other narcotics	◯ Yes ◯ No	Latex (rubber)	◯ Yes ◯ No	Sulfa drugs	◯ Yes ◯ No

Other ◯ Yes ◯ No If yes

WOMEN ONLY:

Are you taking oral contraceptives or hormonal replacements?	◯ Yes ◯ No	If yes
Are you pregnant? If Yes, how many weeks?	◯ Yes ◯ No	If yes
Are you nursing?	◯ Yes ◯ No	

DENTAL INFORMATION:

Do your gums bleed when you brush or floss?	◯ Yes ◯ No	If yes
Are your teeth sensitive to cold, hot, sweets or pressure?	◯ Yes ◯ No	If yes
Does food or floss catch between your teeth?	◯ Yes ◯ No	If yes
Is your mouth dry?	◯ Yes ◯ No	
Have you had any periodontal (gum) treatment?	◯ Yes ◯ No	
Do you have a family history of periodontal (gum) disease?	◯ Yes ◯ No	
Have you ever had orthodontic treatment (braces)?	◯ Yes ◯ No	
Have you had any problems associated with previous dental treatment?	◯ Yes ◯ No	If yes
Is your home water supply fluoridated?	◯ Yes ◯ No	
Do you drink bottled or filtered water? If yes, daily, weekly, or occasionally?	◯ Yes ◯ No	If yes
Are you currently experiencing dental pain or discomfort?	◯ Yes ◯ No	If yes
Do you have earaches or neck pain?	◯ Yes ◯ No	
Do you have any clicking, popping or discomfort in the jaw?	◯ Yes ◯ No	
Do you brux or grind your teeth?	◯ Yes ◯ No	
Do you have sores or ulcers in your mouth?	◯ Yes ◯ No	
Do you wear dentures or partials?	◯ Yes ◯ No	
Do you have a fixed bridge?	◯ Yes ◯ No	
Do you have dental implants?	◯ Yes ◯ No	

Do you have or ever had any of the following oral habits?

☐ Cheek/object Chewing	☐ Lip Biting	☐ Mouth Breathing	☐ Sippy Cup
☐ Finger/thumb Sucking	☐ Lip Licking	☐ Nail Biting	☐ Tongue Sucking
☐ Leaning (hand on face)	☐ Lip Sucking	☐ Pacifier	☐ Other

What "other" oral habit do you have?	☐	If yes
Do you participate in active recreational activites?	◯ Yes ◯ No	If yes
Have you ever had a serious injury to your head or mouth?	◯ Yes ◯ No	If yes
Date of your last dental exam:	☐	If yes
What was done at that time?	☐	If yes
Date and type of last dental x-rays:	☐	If yes
What is the reason for your dental visit today?	☐	If yes
How do you feel about your smile?	☐	If yes

MEDICAL CONDITIONS:

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

☐ AIDS/HIV Positive	☐ Convulsions	☐ Hemophilia	☐ Psychiatric Care
☐ Alzheimer's Disease	☐ Cortisone Medicine	☐ Hepatitis A	☐ Radiation Treatments
☐ Anaphylaxis	☐ Diabetes	☐ Hepatitis B or C	☐ Recent Weight Loss
☐ Anemia	☐ Drug Addiction	☐ Herpes	☐ Renal Dialysis
☐ Angina	☐ Easily Winded	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Arthritis/Gout	☐ Eating Disorders	☐ High Cholesterol	☐ Rheumatism
☐ Artificial Heart Valve	☐ Epilepsy or Seizure	☐ Hives or Rash	☐ Scarlet Fever
☐ Artificial Joint	☐ Excessive Bleeding	☐ Hypoglycemia	☐ Shingles
☐ Asthma	☐ Excessive Thirst	☐ Irregular Heartbeat	☐ Sickle Cell Disease
☐ Autoimmune Disease	☐ Fainting Spells/Dizziness	☐ Kidney Problems	☐ Sinus Trouble
☐ Blood Disease	☐ Frequent Cough	☐ Leukemia	☐ Sleep Disorder
☐ Blood Transfusion	☐ Frequent Diarrhea	☐ Liver Disease	☐ Spina Bifida
☐ Breathing Problems	☐ Frequent Headaches	☐ Low Blood Pressure	☐ Stomach/Intestinal Disease
☐ Bruise Easily	☐ Frequent Urination	☐ Lung Disease	☐ Stroke
☐ Cancer	☐ Genital Herpes	☐ Mental Health Disorder	☐ Swelling of Limbs
☐ Chemotherapy	☐ GERD/Persistent Heartburn	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Chest Pains	☐ Heart Attack/Failure	☐ Neurological Disorder	☐ Tonsillitis
☐ COPD	☐ Heart Murmur	☐ Osteoporosis	☐ Tuberculosis
☐ Cold Sores/Fever Blisters	☐ Heart Pacemaker	☐ Pain in Jaw Joint	☐ Tumors or Growths
☐ Congenital Heart Disorder	☐ Heart Trouble/Disease	☐ Parathyroid Disease	☐ Ulcers
☐ Venereal Disease	☐ Yellow Jaundice		

Do you have any disease condition, or problem not listed above that you think I should know about? Please explain: ◯ Yes ◯ No If yes

If you marked Autoimmune disease,what type?: ☐ If yes

If you marked Diabetes Type I or II, specify A1c value: ☐ If yes

If you marked Neurological disorders, specify: ☐ If yes

If you marked Mental health disorder, specify: ☐ If yes

JOINT REPLACEMENT:

Have you had an orthopedic total joint (hip, knee, elbow, finger replacement)? ◯ Yes ◯ No If yes

Have you had any complications? ◯ Yes ◯ No If yes

Date of joint replacement: ☐ If yes

ANTIBIOTIC RECOMMENDATION:

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If yes, name: ◯ Yes ◯ No If yes

NOTE: Both Dental Professional and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the information given on this form is accurate.
I understand the importance of a truthful health history and that my dental professional will rely on this information for treating me.
I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction.
I will not hold KVCC Dental Hygiene Clinic, or any other staff member or student, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent or Guardian:

X

Date:_____