SRJC Health History Form

Name: _____ Home Phone ( )_____ Cell Phone ( ) _____
Last First Middle

Address _____ City_____ State_____ Zip Code _____
P.O. Box or Mailing address

Occupation _____ Business Phone _____ Date of Birth ____/____/____ Sex ☐M ☐F

Email_____ Text message _____

Emergency Contact _____ Relationship _____ Phone (___)_____

If you are completing this form for another person, what is your relationship to that person? _____
Name Relationship

For the following questions, please *circle* **YES / NO / DON'T KNOW** or write in the appropriate response. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. SRJC does not use this information to discriminate**.**

What is the main reason for your visit?_____

Medical Information

1. How would you rate your health? ☐ Good ☐ Fair ☐ Poor
2. Has there been any change in your general health within the past year? ……...…..Yes No Don't Know
   If yes, explain_____
3. My last physical examination was on _____
4. Are you under the care of a physician?...Yes No Don't Know
   If so, what is the condition being treated? _____
   _____
5. The name and address of my physician(s) is
   Name_____
   Phone_____
   Street Address _____
   City/State/Zip_____
6. Have you had any serious illness, operation, or been hospitalized in the past 5 years?..... .....Yes No Don't Know
   If so, what was the illness or problem? _____
   _____
7. Are you taking or have you recently taken any of the following medications?
   a. Antibiotics or sulfa drugs..... Yes No Don't Know
   b. Anticoagulants (blood thinners) ..... Yes No Don't Know
   c. High blood pressure medication..…... Yes No Don't Know
   d. Cortisone ..... Yes No Don't Know
   e. Aspirin ..... Yes No Don't Know
   f. Bisphosphonates. …….....Yes No Don't Know
   g. Insulin, tolbutamide…….....Yes No Don't Know
   h. Digitalis..... Yes No Don't Know
   i. Nitroglycerin..... Yes No Don't Know
   j. Antihistamine..... Yes No Don't Know
8. Are you taking any medication(s) including non-prescription and herbal medications? If so, what medicine(s) are you taking?
   Prescribed:
   _____
   _____
   _____
   _____
   _____
   Over the Counter:_____
   _____
   Natural/herbal preparations_____
   _____
9. Do you have active Tuberculosis?..... Yes No Don't Know
10. Do you have a persistent cough greater than a 3 week duration or cough that produces blood?..... Yes No Don't Know

Bleeding Problems

11. Have you had abnormal bleeding?..... Yes No Don't Know
12. Have you ever had a blood transfusion? Yes No Don't Know
    If yes, when _____
13. Do you have a blood disorder (anemia, hemophilia, leukemia)?.....…… Yes No Don't Know
    If yes, please explain_____

Premedication (Antibiotic)

14. Has a dentist or physician ever recommended that you take antibiotics prior to dental treatment?..... Yes No Don't Know
    if yes, for what condition? _____
15. Do you have any of the following medical problems?
    a. Prosthetic cardiac valve…….…….. Yes No Don't Know
    b. Previous endocarditis…….. Yes No Don't Know
    c. Congenital heart disease, unrepaired, including palliative shunts and conduits…… Yes No Don't Know
    d. Congenital heart disease, repaired, with prosthetic device…….. Yes No Don't Know
    e. Cardiac transplantation…….. Yes No Don't Know
16. Have you had an orthopedic total joint (knee, hip or other joint) replacement?. . Yes No Don't Know
    If yes, date of surgery? _____
    a. For this condition, has your surgeon directed you to take antibiotics before dental treatment yes _____ no _____

Cardiovascular Diseases

17. Have you had a heart attack?...…… Yes No Don't Know
    If yes, When?_____
18. Have you had a stroke?...……..…… Yes No Don't Know
    If yes, When?_____
19. Do you have chest pain upon exertion? Yes No Don't Know
20. Are you ever short of breath after mild exercise or when lying down?. ……..…… Yes No Don't Know
21. Do you have a cardiac pacemaker?..... Yes No Don't Know
22. Do you have any of the following Cardiovascular problems?
    a. Coronary insufficiency..... Yes No Don't Know
    b. Angina……..... Yes No Don't Know
    c. High blood pressure…..... Yes No Don't Know
    d. Low blood pressure…..... Yes No Don't Know
    e. Arteriosclerosis …….....Yes No Don't Know

Diabetes

23. Do you have Diabetes? ……..... Yes No Don't Know

IF YES, please answer the next three questions:

What type? ……Type I____ Type II____

Have you eaten today? …… Yes____ No ____

What was you glucose count this morning? _____

Other Diseases

24. Have you ever had any treatment for a tumor or growth (surgery, radiation, or chemotherapy)?.. Yes No Don't Know

If yes, please explain_____

25. Do you have or have you had any of the following diseases or problems?

a. Asthma or hay fever……..Yes No Don't Know

Do you have your inhaler with you? Yes ____ No ____

b. AIDS or HIV infection…….... Yes No Don't Know

c. Arthritis, rheumatism..... Yes No Don't Know

d. Cancer…… Yes No Don't Know

e. Chronic pain…….. Yes No Don't Know

f. Eating Disorder…… Yes No Don't Know

g. Epilepsy …… Yes No Don't Know

h. Fainting spells or seizures…… Yes No Don't Know

i. G.E. reflux……..... Yes No Don't Know

j. Glaucoma…….…….. Yes No Don't Know

k. Hepatitis, jaundice or liver disease… Yes No Don't Know

l. Kidney Trouble.....…..... Yes No Don't Know

m. Mental Health Problems……..Yes No Don't Know

n. Mononucleosis..... Yes No Don't Know

o. Oral herpes/ cold sores/ fever blister. Yes No Don't Know

p. Osteoporosis.....…..... Yes No Don't Know

q. Persistent swollen glands in neck…... Yes No Don't Know

r. Problems of the immune system...… Yes No Don't Know

s. Recurrent infections…… Yes No Don't Know

t. Respiratory problems……..... Yes No Don't Know

If yes, please specify type (emphysema**,** bronchitis, other)

_____

u. Severe headaches……..…. Yes No Don't Know

v. Sexually Transmitted Disease (syphilis, gonorrhea, chlamydia, etc).....….....Yes No Don't Know

w. Sinus trouble……..Yes No Don't Know

x. Stomach ulcer or hyperacidity..... Yes No Don't Know

y. Systemic lupus erythematosus……Yes No Don't Know

z. Thyroid problems…….….. Yes No Don't Know

Allergies

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

a. Aspirin…….….. Yes No Don't Know

If yes, specify reaction_____

b. Barbiturates.....Yes No Don't Know

If yes, specify reaction_____

c. Codeine or other narcotics.....Yes No Don't Know

If yes, specify reaction_____

d. Food…….…….....Yes No Don't Know

If yes, specify food and reaction_____

e. Iodine……..Yes No Don't Know

If yes, specify reaction_____

f. Latex.....Yes No Don't Know

If yes, specify reaction_____

g. Local anesthesia…….….....Yes No Don't Know

If yes, specify reaction_____

h. Penicillin.....Yes No Don't Know

If yes, specify reaction_____

i. Seasonal allergies……Yes No Don't Know

If yes, specify reaction_____

j. Sulfa drugs…….….....Yes No Don't Know

If yes, specify reaction_____

k. Other.....Yes No Don't Know

If yes, specify reaction_____

27. Do you have any disease, condition, or problem not listed that I should know about?.....Yes No Don't Know

If so explain_____

Tobacco/Alcohol/Drugs

28. Do you use tobacco of any type?..... Yes ____ No ____

If so, which type? _____ How long?_____

29. Are you a former tobacco user?..... Yes ____ No ____

30. Do you currently use alcoholic beverages? Yes ____ No ____

31. Are you in recovery for alcoholism/substance abuse?.....Yes____ No____

32. Do you use recreational drugs?.....Yes ____ No ____

33. Do you use medical marijuana?……..Yes_____ No____

For women only:

34. Are you pregnant?..... Yes No Don't Know

If yes, due date?_____

35. Are you taking birth control (pills, injections or implants)?..... Yes No Don't Know

If yes, please explain_____

36. Are you taking hormone replacement?.....Yes No Don't Know

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold SRJC, or any member of the staff, 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/Legal Guardian Date

Initial vitals: BP_____ _P_____ R_____

Stage _____ **ASA Classification** _____

Relationship to patient_____

Faculty Screening signature_____

How did you hear about the SRJC Dental Clinic?

Flyer____ SRJC Catalog ____ Student Contact _____ Word of Mouth _____ Referral _____ Other_____

Patient Name_____

FOR COMPLETION BY STUDENT OPERATOR

Significant findings from questionnaire or oral interview: please always place the number that corresponds to the HH questionnaire and use a separate line for each question on the HH.

_____ /student # _____ _____

Signature of Student Signature of faculty Date

Adapted from Wilkin
11nd Edition, 2013

DDS Signature for Patient of Record _____

Revised and posted 7/16

SRJC Dental History Form

Patient Name_____ Date_____

1. The name and address of my dentist is:
   Name_____ Phone_____

   Street Address_____ City/State/Zip_____

2. Date of last dental cleaning _____ Date of your last dental x-rays_____

3. Are you nervous about receiving dental treatment?
   Yes ___ Explain why_____ No ____

4. Are you experiencing any of the following symptoms (Circle any that apply)

My teeth are Sensitive to:	I have (an):		I am worried about:
Hot	Abscess	Difficulty Chewing	Gum Recession
Cold	Toothache/Broken Tooth	Difficulty Swallowing	Dry Mouth
Sweet	Burning Sensation	Calculus Buildup	Bad Breath
Pressure	Filling that fell out	Other Concern:_____	

5. Have you experienced any of the following? When (month, year)?

Root planning	_____	Head/neck radiation therapy	_____	Bad reaction to a local anesthetic	_____
Root Canal	_____	Periodontal Surgery	_____	Headaches, earaches or neck pains	_____
Tooth extraction	_____	Prolonged bleeding after	_____	Other	_____

6. Have you ever had orthodontic (braces) treatment? Yes _____ If yes, for how long? _____ No _____

   Did you wear a retainer? Yes _____ permanent or removable? _____ No _____

7. Do you wear a removable dental prosthesis (denture, partial)? Yes _____ No _____

8. Do you have any dental implants? Yes _____ No _____

9. Do you clench or grind your teeth in the daytime or at night? Yes _____ No _____

   If yes, do you wear a night guard/ bite guard?_____ For how long? _____

10. Have you experienced any injuries to your teeth, face or jaw?
    Yes _____ Explain_____
    No _____

11. About how many times each day / week do you brush and floss?
    Brush: _____ x per day OR _____ x per week **Floss:** _____ x per day OR _____ x per week

12. Do you agree or disagree with this statement: Oral health affects general health.

    Strongly agree Agree Disagree Strongly disagree

13.

When you look inside your mouth, do you look for any of the following?	Yes	No	Don't Know How
Caries			
Oral Cancer			
Cold Sores			
Gingival Disease			

14. In the past two years, have you been concerned about your breath or the appearance of your teeth or face?
    Yellowing/ graying teeth Spacing between teeth Other
    Stains Gingiva Breath