

# 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 your 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 \_\_\_\_\_

How did you hear about the SRJC Dental Clinic?

Flyer \_\_\_ SRJC Catalog \_\_\_ Student Contact \_\_\_ Word of Mouth \_\_\_ Referral \_\_\_ Other \_\_\_\_\_



## 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 _____	
<input type="checkbox"/> 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

