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? _____
Your 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 your assigned student will follow-up with questions about your responses and they may ask additional questions concerning your health. This information is vital to allow us to provide appropriate and safe 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? _____

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. Steroids ..... **Yes No Don't Know**
e. Aspirin ..... **Yes No Don't Know**
f. Bisphosphates ..... **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/ Vaping

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

If so, which type? _____

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 _____

If yes, due date? _____

35. Are you taking birth control (pills, injections, or implants)? ..... Yes _____ No _____

36. Are you taking hormone replacement? ..... Yes _____ No _____

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.

_____ Initial vitals: BP_____ P_____ R_____

Signature of Patient/Legal Guardian Date Stage _____ ASA Classification_____

Relationship to Patient _____

Student Name/# _____ Date_____ Student Signature _____

Faculty Signature _____Date _____ DDS Signature _____

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? Yes___ No___ 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? Yes_____ For how long? _____ No _____
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/ greying teeth	Spacing between teeth	Other
Stains	Gingiva	Breath