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.

____

Signature of Patient/Legal Guardian Date

Initial vitals: BP______ P______ R______

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