SANTA ROSA JUNIOR COLLEGE
DENTAL HYGIENE PROGRAM
CLINICAL MEDICAL HISTORY SCREENING FORM

Last Name:_______________________________First Name:_____________________________

Date of birth_______________________________

Home Address________________________________State_______Zip Code_____________

Phone Number_______________________________

Name of physician:____________________________Phone number______________________

**Please circle Yes or No for the following questions**:

Do you normally require antibiotic premedication before dental appointments?...............................YES NO
Have you ever had any abnormal reaction to local anesthetic(novacaine)?....................................YES NO
Do you smoke?........................................................................................................................ YES NO
Are you pregnant?.....................................................................................................................YES NO

Are you currently under the care of a medical doctor?..................................................................... YES NO
Are you currently taking **any perscription drugs**?..........................................................................YES NO
**(Please list below any medications you are taking)**
Have you been hospitalized in the last 12 months?...........................................................................YES NO

Please list current
medications:_____________________________________________________________________________

Please list any allergies you may have( latex, local anesthesia, etc):____________________________________

**Do you have, or have you ever had, any of the following medical conditions**
**Please circle YES or NO**

Steroid therapy………….Yes No Rheumatic fever………..Yes No Asthma……………………..Yes No
Heart problems………….Yes No Cardiac pacemaker…….Yes No Osteoporosis………………..Yes No
Radiation therapy……….Yes No Epilepsy………………….Yes No Kidney disease……………..Yes No
Excessive bleeding……..Yes No Stroke…………………....Yes No Cancer………………………..Yes No
Bronchitis, Emphysema..Yes No Thyroid Disease………...Yes No High/Low blood pressure…..Yes No
Anxiety…………………...Yes No Hepatitis/Liver disease...Yes No Diabetes…………………….. Yes No
Knee or Hip
replacement……………...Yes No Any other conditions…...Yes No (please explain_____________________)

**Patient Signature**________________________________________**Date**___________________

**Student**______________________#________ **Faculty Signature**____________________________________