Clark College
Dental Hygiene Department

Medical History

PLEASE PRINT Date_____

Patient's Name_____ Home Phone (____)_____
Last First MI Cell Phone (____)_____

Patient's Address_____
Street City State ZIP

Date of Birth_____Age_____Gender ❑ M ❑ F ❑ Other Occupation_____

Emergency Contact: Name _____ Phone (____)_____

Physician's Name_____ Phone (____)_____

Address_____
Street City State ZIP

Dentist's Name_____ Phone (____)_____

Address_____
Street City State ZIP

Please answer the following questions by checking Yes or No or filling in the blank where indicated.

Do you have or have you had any of the following? Please mark all that apply.

A.	**General Information**	
1.	How would you rate your health? ❑ Good ❑ Fair ❑ Poor	
2.	Has there been any change in your general health within the past two years?	❑ Yes ❑ No
3.	Have you ever been hospitalized, had surgery, or day surgery in a hospital setting?	❑ Yes ❑ No
4.	Are you now under the care of a physician? Last exam date?	❑ Yes ❑ No
5.	Are you now under the care of a dentist? Last exam date?	❑ Yes ❑ No
6.	Do you use tobacco products?	❑ Yes ❑ No
B.	**Central Nervous System**	
1.	Epilepsy, seizures, or convulsions	❑ Yes ❑ No
2.	Fainting spells	❑ Yes ❑ No
3.	Multiple Sclerosis, Cerebral Palsy, or Parkinson's Disease	❑ Yes ❑ No
4.	Frequent or severe headaches	❑ Yes ❑ No
5.	Trouble sleeping or chronically tired	❑ Yes ❑ No
C.	**Musculo-Skeletal System**	
1.	Arthritis, rheumatism, or swollen joints	❑ Yes ❑ No
2.	Back or neck pain	❑ Yes ❑ No
3.	Joint replacement (e.g., knee, hip, pins, or implants)	❑ Yes ❑ No
4.	Osteoporosis	❑ Yes ❑ No
D.	**Gastrointestinal System**	
1.	Stomach ulcers, esophageal ulcers, or frequent heartburn	❑ Yes ❑ No
2.	Liver disease/Jaundice	❑ Yes ❑ No
3.	Unintentional weight loss or weight gain (if more than 10 pounds in the last year)	❑ Yes ❑ No
E.	**Urinary System**	
1.	Kidney disease/dialysis/transplant	❑ Yes ❑ No
F.	**Endocrine System**	
1.	Diabetes	❑ Yes ❑ No
2.	Frequent urination	❑ Yes ❑ No
3.	Thirsty much of the time	❑ Yes ❑ No
4.	Dry mouth much of the time	❑ Yes ❑ No
5.	Rapid weight loss/gain	❑ Yes ❑ No
6.	Thyroid disease	❑ Yes ❑ No

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G.	**Respiratory System**	
1.	Emphysema	❑ Yes ❑ No
2.	Chronic bronchitis	❑ Yes ❑ No
3.	Chronic cough	❑ Yes ❑ No
4.	Hay fever/sinus problems	❑ Yes ❑ No
5.	Asthma	❑ Yes ❑ No
6.	Require inhaler	❑ Yes ❑ No
H.	**Cardiovascular System**	
1.	Cardiac transplant	❑ Yes ❑ No
2.	Heart valve problem or mitral valve prolapsed	❑ Yes ❑ No
3.	Artificial heart valve	❑ Yes ❑ No
4.	Pacemaker/defibrillator	❑ Yes ❑ No
5.	Congenital heart disease	❑ Yes ❑ No
6.	Infective (bacterial) endocarditis	❑ Yes ❑ No
7.	Heart murmur	❑ Yes ❑ No
8.	Heart attack	❑ Yes ❑ No
9.	Heart failure	❑ Yes ❑ No
10.	Angina pectoris/chest pain	❑ Yes ❑ No
11.	Stroke/TIA	❑ Yes ❑ No
12.	Shortness of breath	❑ Yes ❑ No
13.	Ankles swell	❑ Yes ❑ No
14.	Dietary restrictions	❑ Yes ❑ No
15.	Blood pressure problem	❑ Yes ❑ No
I.	**Hematologic System**	
1.	Anemia	❑ Yes ❑ No
2.	Leukemia	❑ Yes ❑ No
3.	Hemophilia/bleeding problem/excessive bleeding	❑ Yes ❑ No
4.	Bruise easily	❑ Yes ❑ No
J.	**Immune System**	
1.	Allergies	❑ Yes ❑ No
2.	Latex allergy	❑ Yes ❑ No
3.	Skin rashes or hives	❑ Yes ❑ No
4.	Cold sores, canker sores, fever blisters	❑ Yes ❑ No
5.	Enlarged lymph node or gland(s)	❑ Yes ❑ No
6.	Autoimmune disease	❑ Yes ❑ No
K.	**Are you allergic or have you had a bad reaction to any of the following?**	
1.	Local anesthetics (“Novacaine”)	❑ Yes ❑ No
2.	Penicillin or other antibiotics	❑ Yes ❑ No
3.	Sulfites	❑ Yes ❑ No
4.	Barbiturates, sedatives, or sleeping pills	❑ Yes ❑ No
5.	Aspirin, Acetaminophen, or Ibuprofen	❑ Yes ❑ No
6.	Codeine, Demerol, or other narcotics	❑ Yes ❑ No
7.	Reaction to metals	❑ Yes ❑ No
8.	Other	❑ Yes ❑ No
L.	**Oncology**	
1.	Lumps, tumors, or growths	❑ Yes ❑ No
2.	Treatment for cancer with surgery, radiation, or chemotherapy	❑ Yes ❑ No
M.	**Bacterial/Viral Conditions**	
1.	Sexually transmitted diseases	❑ Yes ❑ No
2.	AIDS or HIV positive	❑ Yes ❑ No
3.	Tuberculosis	❑ Yes ❑ No
4.	Hepatitis	❑ Yes ❑ No
N.	**Sensory System**	
1.	Eye disorder (such as glaucoma, macular degeneration, cataracts, or blindness	❑ Yes ❑ No
2.	Wear a hearing aid or hard of hearing	❑ Yes ❑ No

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Do you have or have you had any of the following? Please mark all that apply.

O. Personal Well-Being	
1. Depression or treatment for depression	❑ Yes ❑ No
2. Anxiety disorder	❑ Yes ❑ No
3. Dementia or Alzheimer's Disease	❑ Yes ❑ No
4. Psychiatric condition	❑ Yes ❑ No
5. Drug or alcohol addiction	❑ Yes ❑ No
6. Eating disorder	❑ Yes ❑ No
7. ADHD/ADD (Attention Deficit/Hyperactivity Disorder)	❑ Yes ❑ No
8. PTSD (Post-traumatic stress disorder)	❑ Yes ❑ No
P. Mental Limitation(s)	❑ Yes ❑ No
Q. Physical Limitation(s)	❑ Yes ❑ No
R. Are you taking any of the following?	
1. Antibiotics	❑ Yes ❑ No
2. Blood-thinning medication(s)	❑ Yes ❑ No
3. Blood pressure medication(s)	❑ Yes ❑ No
4. Tranquilizers	❑ Yes ❑ No
5. Insulin or oral medication(s) for Diabetes	❑ Yes ❑ No
6. Aspirin/Ibuprofen	❑ Yes ❑ No
7. Digitalis or medication(s) for heart trouble	❑ Yes ❑ No
8. Nitroglycerin	❑ Yes ❑ No
9. Cortisone (steroids)	❑ Yes ❑ No
10. Natural remedies/supplements	❑ Yes ❑ No
11. Non-prescription medication(s)	❑ Yes ❑ No
12. Hormone replacement or any other type of hormones	❑ Yes ❑ No
13. Recreational drugs within the last 24 hours	❑ Yes ❑ No
Are you taking or have you taken bone strengthening medication(s) (i.e. Fosamax, Zometa, Boniva, Actonel, Aredia, Didronel) either orally or as an IV treatment?	❑ Yes ❑ No
List current medication(s) and for what condition(s).	

MEDICATION	CONDITION

Are there any medication(s) your doctor has prescribed that you are not taking?	❑ Yes ❑ No
Have you ever taken doctor prescribed weight reduction medication(s) (e.g., fen-phen, Redux, Ionamin, Fastin)?	❑ Yes ❑ No
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	❑ Yes ❑ No
Women	
1. Are you taking birth control pills?	❑ Yes ❑ No
2. Are you pregnant? If yes, expected delivery date?	❑ Yes ❑ No
3. Are you nursing?	❑ Yes ❑ No
4. Have you reached menopause? If yes, do you have any symptoms?	❑ Yes ❑ No

I certify that I speak, read, and write English, or have had a translator explain all of the questions to me, and I understand all of the information I have read or have had translated to me. To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medication changes, I agree to inform the student and the dentist as soon as possible.

Signed_____ Date_____
Patient

Signed_____ Date_____
Parent or Guardian (if Patient is a Minor)

_____ _____

PLEASE PRINT Name of Person Completing the Medical History (if not Patient) Relationship to Patient