Rowan College at Burlington County

Rowan College at Burlington County Dental Hygiene Clinic

HEALTH HISTORY FORM

Adhere medical alert sticker here if applicable.

Email: _____ **Today's Date:** ____/____/____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that 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. This office does not use this information to discriminate.

Name: _____ **Home phone:** (____) _____ **Business/Cell phone:** (____) _____

LAST FIRST MIDDLE INITIAL *Please include area codes with all phone numbers*

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Occupation: _____ **Height:** _____ **Weight:** _____ **Date of Birth:** ____/____/____ **Sex:** ❑ M ❑ F

Emergency Contact: _____ **Relationship:** _____

Home phone: (____) _____ **Cell phone:** (____) _____

IF YOU ARE COMPLETING THIS FORM FOR ANOTHER PERSON, WHAT IS YOUR RELATIONSHIP TO THAT PERSON?

Your name: _____ Relationship: _____

Do you have any of the following diseases or problems? *(Check DK if you don't know the answer to any of the questions)*	**YES**	**NO**	**DK**
Active tuberculosis	❑	❑	❑
Persistent cough greater than a 3-week duration	❑	❑	❑
Cough that produces blood	❑	❑	❑
Been exposed to anyone with tuberculosis	❑	❑	❑

If you answered yes to any of the 4 items above, please stop and return this form to the receptionist.

DENTAL INFORMATION – Please mark (X) your responses to the following questions.

	YES	**NO**	**DK**
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	❑	❑
Does food or floss catch between your teeth?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had any orthodontic (braces) treatment?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑

If yes, how often? Circle one: DAILY WEEKLY OCCASIONALLY

What is the reason for your dental visit today? _____

_____

_____

How do you feel about your smile? _____

_____

	YES	**NO**	**DK**
Are you currently experiencing dental pain or discomfort?	❑	❑	❑
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you brux or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑

Date of your last dental exam: ____/____/____

What was done? _____

_____

Date of last dental X-rays: ____/____/____

Dentist name and contact information: _____

_____

_____

_____

MEDICAL INFORMATION – Please mark (X) your responses to indicate if you have or have not had any of the following diseases or problems.

	YES	**NO**	**DK**
Are you now in the care of a physician?	❑	❑	❑

Physician's name: _____

Phone number: (____) _____

Address: _____

City/State/ZIP: _____

Are you in good health?	❑	❑	❑
Has there been any change in your general health within the past year?	❑	❑	❑

If yes, what condition is being treated?

Date of your last physical exam: ____/____/____

	YES	**NO**	**DK**
Have you had a serious illness, operation or been hospitalized in the past five years?	❑	❑	❑

If yes, what was the illness or problem? _____

_____

Are you taking or have you recently taken any prescription or over-the-counter medicine(s)?	❑	❑	❑

If yes, please list them all, including vitamins natural or herbal preparations, and/or any diet supplements: _____

_____

_____

_____

Please complete both sides of this form.

	YES	NO	DK
Do you wear contact lenses?	❑	❑	❑

JOINT REPLACEMENT:

Have you had an orthopedic joint replacement (hip, knee, elbow or finger) replacement?	❑	❑	❑
Date: _____/_____/_____			
If yes, have you had any complications?	❑	❑	❑
Are you taking or scheduled to begin taking either of the following medications: alendronate (Fosomax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?	❑	❑	❑

	YES	NO	DK
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous biophosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	❑	❑	❑
Date treatment began: _____/_____/_____			
Do you use recreational drugs?	❑	❑	❑
What is you weekly alcohol consumption? _____			
Do you use tobacco (smoking, snuff, chew, bidis)?	❑	❑	❑
If yes, are you interested in stopping? Circle one: YES SOMEWHAT NO			

WOMEN ONLY:

Are you pregnant?	❑	❑	❑
If yes, how many weeks? _____			
Are you taking birth control pills or hormonal replacement?	❑	❑	❑
Are you nursing?	❑	❑	❑

ALLERGIES:

Are you allergic to or have you had a reaction to any of the following? *If yes, please specify the type of reaction you had.*			
Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbituates, sedatives, or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Metals	❑	❑	❑
Latex (rubber)	❑	❑	❑
Iodine	❑	❑	❑
Hay fever/seasonal allergies	❑	❑	❑
Animals	❑	❑	❑
Food	❑	❑	❑
Other	❑	❑	❑

Artificial (prosthetic) heart valve	❑	❑	❑
Previous infective endocarditis	❑	❑	❑
Damaged valves in a transplanted heart	❑	❑	❑
CONGENITAL HEART DISEASE (CHD)			
Unrepaired, cyanotic CHD	❑	❑	❑
Repaired completely in the last six months	❑	❑	❑
Repaired CHD with residual defects	❑	❑	❑

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	YES	NO	DK
Cardiovascular disease	❑	❑	❑
Angina	❑	❑	❑
Congestive heart failure	❑	❑	❑
Damaged heart valves	❑	❑	❑
Heart attack	❑	❑	❑
Heart murmur	❑	❑	❑
Low blood pressure	❑	❑	❑
High blood pressure	❑	❑	❑
Other congenital heart defects	❑	❑	❑
Mitral valve prolapse	❑	❑	❑

	YES	NO	DK
Pacemaker	❑	❑	❑
Rheumatic fever	❑	❑	❑
Rheumatic heart disease	❑	❑	❑
*Abnormal bleeding	❑	❑	❑
*Anemia	❑	❑	❑
*Blood transfusion	❑	❑	❑
If yes, date: _____			
*Hemophilia	❑	❑	❑
*AIDS or HIV infection	❑	❑	❑
Arthritis	❑	❑	❑
Autoimmune disease	❑	❑	❑

	YES	NO	DK
Rheumatoid arthritis	❑	❑	❑
Systematic lupus erythematosus	❑	❑	❑
Asthma	❑	❑	❑
Bronchitis	❑	❑	❑
Emphysema	❑	❑	❑
Sinus trouble	❑	❑	❑
Tuberculosis	❑	❑	❑
Cancer/chemotherapy/ radiation treatment	❑	❑	❑
Chest pain upon exertion	❑	❑	❑
Chronic pain	❑	❑	❑
Diabetes - Type I or II	❑	❑	❑
Eating disorder	❑	❑	❑
Malnutrition	❑	❑	❑
Gastrointensinal disease	❑	❑	❑
G.E.Reflux/persistent heartburn	❑	❑	❑
Ulcers	❑	❑	❑
Thyroid problems	❑	❑	❑
Stroke	❑	❑	❑
Glaucoma	❑	❑	❑

	YES	NO	DK
Epilepsy	❑	❑	❑
Hepatitis, jaundice, or liver disease	❑	❑	❑
Fainting spells or seizures	❑	❑	❑
Neurological disorder	❑	❑	❑
If yes, specify: _____			
Sleep disorder	❑	❑	❑
Mental health disorder	❑	❑	❑
If yes, specify: _____			
Recurrent infections	❑	❑	❑
If yes, specify: _____			
Kidney problems	❑	❑	❑
Night sweats	❑	❑	❑
Osteoporsis	❑	❑	❑
Persistent swollen glands in neck	❑	❑	❑
Severe headaches or migraines	❑	❑	❑
Severe/rapid weight loss	❑	❑	❑
Sexually transmitted disease	❑	❑	❑
Excessive urination	❑	❑	❑

Has a physician or previous dentist recommend that you take antibiotics prior to your dental treatment?	❑	❑	❑
If yes, please provide the name and phone number: _____ ( ) _____			
Do you have any disease, condition, or problem not listed above that you think should be disclosed?	❑	❑	❑
If yes, please explain _____			

NOTE: Both dental staff and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above, and that the information given on this form is accurate. I understand the importance of a truthful health history and that the RCBC staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold RCBC or any other member of the staff 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: ___/___/___ Student signature: _____ Instructor: _____

Signature of patient/legal guardian: _____ Date: ___/___/___ Student signature: _____ Instructor: _____

Signature of patient/legal guardian: _____ Date: ___/___/___ Student signature: _____ Instructor: _____

FOR COMPLETION BY INSTRUCTOR – Comments: _____