



Rowan College at Burlington Country HEALTH HISTORY FORM

Adhere medical alert sticker here if applicable

Date: ____ / ____ / ____

Patient's Name: _____ Preferred Name: _____
LAST FIRST MIDDLE INITIAL

Preferred Pronoun (circle): He/Him She/Her They/Them Date of Birth: _____ Age: _____

Address: _____
STREET CITY STATE ZIP

Phone: (____) _____ Type (circle): Home Cell Work Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

	YES	NO	DK
Have you had any of the following diseases or problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. Active Tuberculosis, 2. Persistent cough greater than 3 week duration, 3. Cough that produces blood, 4. Exposed to someone with tuberculosis?			
<i>If you answered yes to any of the above 4 questions, please stop and return this form to the receptionist.</i>			

DENTAL INFORMATION- Please mark your responses to the following questions

	YES	NO	DK		YES	NO	DK
Do your gums bleed when you brush or floss?..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently experiencing dental pain or discomfort?..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot or sweets?.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any popping or discomfort in the jaw?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had periodontal/gum treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had orthodontic (braces) treatment?..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in recreational activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink bottled or filtered water?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam: ____ / ____ / ____			
If so, how often? (circle one) DAILY WEEKLY OCCASIONALLY				What was done? _____			
What is the reason for your dental visit today? _____				Date of last dental x-rays: ____ / ____ / ____			
How do you feel about your smile? _____				Dentist name and contact information: _____			

MEDICAL INFORMATION- Please mark your response to the following questions

	YES	NO	DK		YES	NO	DK
Are you now in the care of a physician?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the last 5 years?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician's name: _____				If yes, what was the illness or problem? _____			
Phone number: _____							
Address: _____				Are you taking any prescription or over the counter medications?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
City/State/Zip: _____				If yes, please list them all, including vitamins, natural supplements:			
Are you in good health?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
Has there been any change in your general health within the past year?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated? _____				_____			
Date of your last physical exam? ____ / ____ / ____				_____			

Please complete both sides of this form.

	YES	NO	DK		YES	NO	DK
Do you wear contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been treated with intravenous bisphosphonates (Reclast, Aredia, Boniva) for bone pain, hypercalcemia, Paget's disease, multiple myeloma, or metastatic cancer?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
JOINT REPLACEMENT:				Date treatment began: _____ / _____ / _____			
Have you had and orthopedic joint replacement (hip, knee, elbow, or finger) replacement?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use recreational drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date of replacement: _____ / _____ / _____				What is your weekly alcohol consumption?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, have you had any complications?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke (cigarettes, cigars, marijuana, vape, hookah) or use smokeless tobacco?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you taking or scheduled to start taking any medications for osteoporosis?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, are you interested in quitting?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
WOMEN ONLY:	YES	NO	NA		YES	NO	NA
Are you pregnant?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking birth control or hormonal replacement?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, how many weeks? _____				Are you nursing?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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.

	YES	NO	DK		YES	NO	DK
Local anesthetics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal allergies.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other medication(s)- please specify.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Any other allergy- please specify.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<i>The following conditions require antibiotic prophylaxis prior to dental treatment</i>	YES	NO	DK		YES	NO	DK		YES	NO	DK
Artificial (prosthetic) heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous history of infective endocarditis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date: _____				Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves in a transplanted heart.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorder....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART DISEASE (CHD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/seizures.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired completely in the last 6 months.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual effect.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental health disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Chronic Bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes: specify: _____			
				Tuberculosis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder			
YES NO DK	YES	NO	DK	Sinus trouble.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent infections..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe migraines.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GERD/Reflux/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, date: _____				Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina/ Chest Pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date: _____			
Low blood pressure....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV or AIDS.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defects.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?.....

If yes, please explain: _____

Do you have any disease, condition, or problem not listed above?.....

If yes, please explain: _____

NOTE: Both dental team 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 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: _____ Date: _____

Instructor Signature: _____ Date: _____