PARKLAND COLLEGE
Dental Hygiene Clinic
Room L148 • 217/351-2221

Medical History

ASA _____

❑ MC see numbers _____

PATIENT'S NAME (last)	(first)	HEIGHT	WEIGHT	BIRTHDATE

HOME ADDRESS	(city)	(state)	(zip code)	HOME PHONE ( )

SCHOOL/BUSINESS ADDRESS	(city)	(state)	(zip code)	CELL/BUS. PHONE ( )

OCCUPATION	SEX ❑ M ❑ F	RACE	MARITAL STATUS ❑ Single ❑ Married ❑ Widowed ❑ Divorced

PARENT OR GUARDIAN, IF UNDER 18 (last name first)

EMERGENCY CONTACT AND PHONE NUMBER	LOCAL EMERGENCY FACILITY — 911 ❑ Carle ❑ Provena

PHYSICIAN'S NAME (last name first)	ADDRESS	(zip code)	PHYSICIAN'S PHONE ( )

DENTIST'S NAME (last name first)	ADDRESS	(zip code)	DENTIST'S PHONE ( )

	DATE	DATE	DATE	DATE
1. Has there been any change in your general health within the past year?	Yes/No	Yes/No	Yes/No	Yes/No
2. When was your last visit to a physician?				
What was the reason for the visit?				
3. Are you now under the care of a physician?	Yes/No	Yes/No	Yes/No	Yes/No
If so, what is the condition being treated?				
4. Have you had surgery or a serious illness within the past two years?	Yes/No	Yes/No	Yes/No	Yes/No
If so, describe the problem and when it occurred.				
5. Do you have any physical limitations?	Yes/No	Yes/No	Yes/No	Yes/No
Describe _____				

Do you have or have you ever had:

1. ALLERGIES				
a. Latex	Yes/No	Yes/No	Yes/No	Yes/No
b. Drugs (What?)	Yes/No	Yes/No	Yes/No	Yes/No
c. Local Anesthetics	Yes/No	Yes/No	Yes/No	Yes/No
d. Other (food, animals, dust, pollen)	Yes/No	Yes/No	Yes/No	Yes/No
If so, what?				
2. NEUROLOGIC				
a. Epilepsy, seizures, or convulsions	Yes/No	Yes/No	Yes/No	Yes/No
b. Fainting or dizzy spells	Yes/No	Yes/No	Yes/No	Yes/No
c. Hearing problems—loss, earaches, ringing (circle)	Yes/No	Yes/No	Yes/No	Yes/No
d. Mental limitations (autism, mental retardation, Down Syndrome, etc.)	Yes/No	Yes/No	Yes/No	Yes/No
e. Emotional / mental health disorders	Yes/No	Yes/No	Yes/No	Yes/No
If so, what?_____				
f. Parkinson's Disease	Yes/No	Yes/No	Yes/No	Yes/No
g. Stroke (Date?)_____	Yes/No	Yes/No	Yes/No	Yes/No
h. Vision problems—cataracts, glaucoma, macular degeneration (circle)	Yes/No	Yes/No	Yes/No	Yes/No

	DATE	DATE	DATE	DATE
3. CARDIOVASCULAR				
a. Angina or chest pain (circle)	Yes/No	Yes/No	Yes/No	Yes/No
b. Angioplasty (Date?)	Yes/No	Yes/No	Yes/No	Yes/No
c. Artificial (prosthetic) heart valves (Date?)	Yes/No	Yes/No	Yes/No	Yes/No
d. Arrhythmias (irregular heart beat)	Yes/No	Yes/No	Yes/No	Yes/No
e. Bypass surgery (Date?)	Yes/No	Yes/No	Yes/No	Yes/No
f. Congenital heart defects	Yes/No	Yes/No	Yes/No	Yes/No
g. Congestive heart failure	Yes/No	Yes/No	Yes/No	Yes/No
h. Heart attack (Date?)	Yes/No	Yes/No	Yes/No	Yes/No
i. Heart murmur	Yes/No	Yes/No	Yes/No	Yes/No
j. High blood pressure	Yes/No	Yes/No	Yes/No	Yes/No
k. High blood cholesterol	Yes/No	Yes/No	Yes/No	Yes/No
l. Infection in heart valves or heart (infective endocarditis)	Yes/No	Yes/No	Yes/No	Yes/No
m. Mitral valve prolapsed	Yes/No	Yes/No	Yes/No	Yes/No
n. Pacemaker or defibrillator (Date?)	Yes/No	Yes/No	Yes/No	Yes/No
o. Rheumatic heart disease	Yes/No	Yes/No	Yes/No	Yes/No
p. Shunt or conduit (Date?)	Yes/No	Yes/No	Yes/No	Yes/No
q. Stents (Date?)	Yes/No	Yes/No	Yes/No	Yes/No
r. Other heart problem (What?)	Yes/No	Yes/No	Yes/No	Yes/No
4. ENDOCRINE				
a. Diabetes: Type 1 Type 2 Gestational (circle)	Yes/No	Yes/No	Yes/No	Yes/No
b. Do any of your first generation family members (mother, father, brother, sister) have diabetes?	Yes/No	Yes/No	Yes/No	Yes/No
c. Thyroid disease: Hypo (underactive) Hyper (overactive) (circle)	Yes/No	Yes/No	Yes/No	Yes/No
d. Taking cortisone or other steroid	Yes/No	Yes/No	Yes/No	Yes/No
5. PULMONARY				
a. Asthma	Yes/No	Yes/No	Yes/No	Yes/No
Do you use an inhaler?	Yes/No	Yes/No	Yes/No	Yes/No
What brings on an attack? (Date?)				
b. Breathing difficulties (explain)	Yes/No	Yes/No	Yes/No	Yes/No
c. Cough that lasts more than 3 weeks or cough that produces blood (circle)	Yes/No	Yes/No	Yes/No	Yes/No
d. COPD — chronic bronchitis, emphysema (circle)				
e. Sinus trouble	Yes/No	Yes/No	Yes/No	Yes/No
f. Tuberculosis: Active? _____ When?	Yes/No	Yes/No	Yes/No	Yes/No
If yes, is treatment completed?	Yes/No	Yes/No	Yes/No	Yes/No
6. HEMATOLOGIC				
a. Anemia	Yes/No	Yes/No	Yes/No	Yes/No
If yes, type and when?				
b. Blood transfusion (Date?)	Yes/No	Yes/No	Yes/No	Yes/No
c. Hemophilia	Yes/No	Yes/No	Yes/No	Yes/No
d. Leukemia	Yes/No	Yes/No	Yes/No	Yes/No
e. Portacath (Location?)	Yes/No	Yes/No	Yes/No	Yes/No
f. Bleed longer than normal	Yes/No	Yes/No	Yes/No	Yes/No
If yes, when and why?				

	DATE	DATE	DATE	DATE
7. DERMAL/MUSCULOSKELETAL				
a. Arthritis (juvenile, rheumatoid, osteoarthritis) (circle)	Yes/No	Yes/No	Yes/No	Yes/No
b. Artificial (prosthetic) joint (Date?)	Yes/No	Yes/No	Yes/No	Yes/No
c. Dark mole (appearance change)	Yes/No	Yes/No	Yes/No	Yes/No
If yes, when and location				
d. Night sweats	Yes/No	Yes/No	Yes/No	Yes/No
e. Skin rash	Yes/No	Yes/No	Yes/No	Yes/No
f. Systemic lupus	Yes/No	Yes/No	Yes/No	Yes/No
8. GENITOURINARY				
a. Dialysis	Yes/No	Yes/No	Yes/No	Yes/No
b. HIV positive	Yes/No	Yes/No	Yes/No	Yes/No
c. Kidney, bladder problem	Yes/No	Yes/No	Yes/No	Yes/No
d. Chlamydia, genital herpes, gonorrhea, syphilis (circle)	Yes/No	Yes/No	Yes/No	Yes/No
If yes, when treatment completed?				
e. Urinate frequently	Yes/No	Yes/No	Yes/No	Yes/No
9. GASTROINTESTINAL				
a. Colitis	Yes/No	Yes/No	Yes/No	Yes/No
b. Crohn's disease	Yes/No	Yes/No	Yes/No	Yes/No
c. Eating disorder	Yes/No	Yes/No	Yes/No	Yes/No
If yes, type and treatment				
d. Hepatitis	Yes/No	Yes/No	Yes/No	Yes/No
e. Liver disease	Yes/No	Yes/No	Yes/No	Yes/No
f. Yellow jaundice (when?)	Yes/No	Yes/No	Yes/No	Yes/No
10. OTHER CONDITION				
a. Cancer	Yes/No	Yes/No	Yes/No	Yes/No
If yes, when and what type				
b. Chemotherapy and/or radiation therapy (circle)	Yes/No	Yes/No	Yes/No	Yes/No
If yes, when and why				
c. Drug or alcohol addiction (circle)	Yes/No	Yes/No	Yes/No	Yes/No
d. Enlarged lymph node or gland	Yes/No	Yes/No	Yes/No	Yes/No
If yes, location and how long				
e. Frequent sore throats (when?)	Yes/No	Yes/No	Yes/No	Yes/No
f. Sudden weight loss (when and why?)	Yes/No	Yes/No	Yes/No	Yes/No
g. Transplants — liver, kidney, other (circle)	Yes/No	Yes/No	Yes/No	Yes/No
h. Disease, problem or condition not listed	Yes/No	Yes/No	Yes/No	Yes/No
Explain				
11. Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine), or phen-fen (fenfluramine-phentermine combination)?	Yes/No	Yes/No	Yes/No	Yes/No
12. Are you taking or scheduled to begin taking either of the medications, aledronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?	Yes/No	Yes/No	Yes/No	Yes/No
13. Since 2001, were you treated or are you scheduled to begin treatment with intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia, or skeletel complications resulting from Paget's diesase, multiple myeloma, or cancer?	Yes/No	Yes/No	Yes/No	Yes/No
14. Are you taking any nonprescription medications such as cold or sinus drugs, aspirin, natural or herbal supplements, weight control medications, or other?	Yes/No	Yes/No	Yes/No	Yes/No
If yes, explain				

15. Are you taking any prescription medications?

	Drug	Classification	Dosage	Reason
a.				
b.				
c.				
d.				
e.				
f.				
g.				

14.	Have you taken your medications as directed by your physician?	Yes/No	Yes/No	Yes/No	Yes/No
15.	Are you experiencing any side effect from your medications?	Yes/No	Yes/No	Yes/No	Yes/No
	If yes, explain _____				
16.	WOMEN ONLY: Are you pregnant?	Yes/No	Yes/No	Yes/No	Yes/No
	Circle trimester: First, Second, Third Due date _____				

FOR CLINIC USE ONLY

Additional comments by dentist Date

_____

_____

_____

CHECK THE BOX AND SIGN, IF APPLICABLE.

❑ I have answered these questions to the best of my knowledge for my _____ who is non-English speaking.
(relationship to individual)

Respondee's Signature_____

❑ I give my permission for my child, who is under 18 years of age, to be treated in the Parkland College Dental Hygiene Clinic for as many appointments as is necessary to complete treatment.

Parent or Guardian's Signature_____

I SIGNIFY THAT THE HISTORY OF MY HEALTH CONTAINED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature_____ Date_____

Student's Signature_____ BP_____a.m./p.m.

Instructor's Signature_____ Pulse _____

I SIGNIFY THAT I HAVE REVIEWED THE PATIENT'S HEALTH HISTORY.

Clinical Dentist_____ Date_____

I SIGNIFY THAT THE HISTORY OF MY HEALTH CONTAINED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature_____ Date_____

Student's Signature_____ BP_____a.m./p.m.

Instructor's Signature_____ Pulse _____

I SIGNIFY THAT THE HISTORY OF MY HEALTH CONTAINED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature_____ Date_____

Student's Signature_____ BP_____a.m./p.m.

Instructor's Signature_____ Pulse _____