COMMUNITY COLLEGE OF BALTIMORE COUNTY
DENTAL HYGIENE PROGRAM

Medical Alert:

MEDICAL DENTAL HISTORY FORM

First Name _____ **Last Name** _____

Street Address _____ **P.O. Box #** _____

City _____ **State** _____ **Zip** _____

Phone Number _____ **Email Address** _____

Date of Birth _____ **Race** _____ **Gender** _____

Weight _____ **Height** _____

Person to notify in case of an emergency:

First Name _____ **Last Name** _____

Street Address _____ **P.O. Box #** _____

City _____ **State** _____ **Zip** _____

Daytime Phone Number _____ **Evening Phone Number** _____

Relationship _____

MEDICAL INFORMATION

Please give the name, address and phone number of your PRIMARY CARE PHYSICIAN.

None _____ Phone Number _____

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

1. Current Medications (Prescription, Over-the-Counter and Herbal)

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

Check YES or NO for the following questions.

2. Have you ever been hospitalized, had major operations or a serious illness? ☐YES ☐NO
If so, what? _____

3. Are you under medical treatment now? ☐YES ☐NO
If so, why? _____

4. When was your last medical examination by a physician? _____

5. Past and Current Medical Conditions (Do you HAVE or have you HAD any of the following conditions?)

Cardiovascular Conditions:	**Yes**	**No**	***Blood Conditions:***	**Yes**	**No**
Rheumatic fever/heart disease?			Hemophilia?		
Congenital heart defects or murmurs?			Anemia?		
Heart attack/myocardial infarction?			Leukemia?		
Angina (chest pain)?			Neutropenia?		
Pacemaker?			Blood Transfusion? Date:		
Prosthetic heart value?			***Other Conditions?***		
Bacterial endocarditis?			Diabetes (Type I or Type II)		
Mitral value prolapse?			Epilepsy		
Congestive heart failure?			Hepatitis, jaundice or liver disease?		
Coronary bypass?			Arthritis or inflammatory rheumatism?		
Heart transplant?			Stomach ulcers?		
Arteriosclerosis?			Glaucoma?		
High blood pressure?			Chemical dependency or recovery?		
Low blood pressure?			Kidney trouble?		
Pacemaker?			Seizures or fainting spells?		
Stroke/TIA?			Neurological disorders		
Vascular disease?			Gastrointestinal diseases?		
Blood vessel surgery?			Mental health disorders? Specify:		
Immune Conditions:			Eating disorder? Specify:		
Allergies?			Systemic lupus erythematosus?		
Asthma?			Osteoporosis?		
Hayfever?			Respiratory problems? Specify:		
Skin rash or hives?			***Infections:***		
Hormonal Conditions:			Tuberculosis?		
Thyroid problems?			Mononucleosis?		
Orthopedic Conditions:			HIV infection/AIDS?		
Orthopedic pins, rods or screws?			Herpes?		
Joint replacement?			Sexually transmitted diseases?		
Prosthetic device or implants?			Recurrent infections? Type:		

Check YES or NO for the following questions.

6. Medical Allergies:

Are you allergic to any of the following:

Local anesthetic (novocaine)? ☐YES ☐NO
Barbiturates, sedatives, sleeping pill? ☐YES ☐NO
Penicillin or other antibiotics? ☐YES ☐NO
Aspirin or other pain medicine? ☐YES ☐NO
Sulfa Drugs? ☐YES ☐NO
Iodine? ☐YES ☐NO

Other? _____

7. Have you ever had medical x-ray taken? ☐YES ☐NO
If yes, please specify date and reason. _____

8. Are you wearing contact lens? ☐YES ☐NO

9. Women Only:

Are you currently taking contraceptives? ☐YES ☐NO
Are you currently taking birth control or hormone replacement therapy? ☐YES ☐NO
Are you pregnant? ☐YES ☐NO
Are you presently nursing? ☐YES ☐NO

10. Have you been told you needed to be premedicated with an antibiotic before dental treatment? ☐YES ☐NO

11. If there are any other conditions that you have or medical issues not list above, please identify here.

_____

_____

12. Number of alcoholic beverages you drink in a week? _____

13. Are you currently using any street or recreational drugs? _____ Type _____

14. Tobacco

Tobacco users? ☐YES ☐NO

How soon after you wake, do you use tobacco?

Type: _____ ☐Less than 30 minutes ☐Greater than 30 minutes

Amount: _____

Number of years: _____

Previous attempts to quit? ☐YES ☐NO Former tobacco user? ☐YES ☐NO

Are you interested in quitting tobacco use? ☐YES ☐NO

Number of attempts: _____ Type: _____

Longest period of success: _____ Amount: _____

Methods used: _____ Year quit: _____

Please give the name, address and phone number of your DENTIST.

None _____ Phone Number _____

First Name _____ Last Name _____

Street Address _____

City _____ State _____ Zip _____

1. My last dental cleaning was on? _____

2. My last dental treatment was on? _____ What was done?_____

3. Do you use any of the following oral hygiene cleaning aids?

Floss? ☐YES ☐NO Stimudents? ☐YES ☐NO

Toothpicks? ☐YES ☐NO Other? _____

Rubbertips ☐YES ☐NO _____

4. Do you currently use or have you ever used any of the following?

Fluoride toothpaste? ☐YES ☐NO

Fluoridated water? ☐YES ☐NO

Fluoride mouthrinses? ☐YES ☐NO

Prescription fluoride supplements? ☐YES ☐NO

Other? _____

5. What are some typical food you eat between meals? _____

6. What types of beverages do you typically drink between meals? _____

7. How often do you chew or suck on hard candy, cough drops or mints? _____

8. Rate you ORAL HEALTH in general. ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

9. Do you have consistent problems with:

	Yes	No		Yes	No
Is it important for you to keep your teeth?			Do you need to take an antibiotic prior to dental treatment?		
Do you become usually anxious about having dental treatment?			Do you have any sensitivity or pain in your mouth or teeth?		
Do your gums bleed often when your brush?			Have you noticed loosening of your teeth?		
Have you had an injury to your head, neck or jaw?			Are you allergic to latex materials?		
Do you clench or grind your teeth?			Do you bite your lips or cheeks frequently?		
Do you breathe through your mouth?			Do you suck your thumb or fingers?		
Do you hear popping, clicking or snapping with your jaw?			Have you noticed pain in your jaw joints, ears or face?		
Do you have difficulty chewing, opening or closing your jaw?			Do you have oral or facial piercing?		
Do you have sore facial muscles?			Have you had or do you have any sores in your mouth?		
Have you hade or do you have dry mouth?			Do you have a bad taste in your mouth?		
Does food catch between your teeth?			Are you aware of any swelling or lumps?		
Experienced prolong bleeding after dental treatment?			Do you have difficulty swallowing?		

11. Have you ever had dental x-rays taken? ☐YES ☐NO
If yes, please specify type and date taken: _____

12. Do you perform a monthly self-exam for oral cancer? ☐YES ☐NO

13. Do you have any dental complaints? ☐YES ☐NO
If yes, please explain: _____

BELIEFS ABOUT ORAL HEALTH

1. When compared with the average person, how likely do you believe that you have cavities or other problems with your teeth and/or gums?
☐More than average ☐About average ☐ Less than average

2. How important is it for you to prevent dental decay, gum disease, or other diseases of the mouth?
☐Very important ☐Somewhat important ☐ Not at all important

3. I believe that my oral health is?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

I certified that I have read and understand the above. To the best of my knowledge, the above information is complete and correct. I will not hold The Community College of Baltimore County Dental Hygiene Clinic responsible for any errors or omissions that I may have made in the completion of this form.

_____	_____	_____
Signature of Client/Parent or Guardian	Print Name	Date
_____	_____	_____
Signature of Dental Hygiene Student	Print Name	Date
_____	_____	_____
Signature of Dental Hygiene Faculty	Print Name	Date

Client Name: ___________________________________

I have reviewed my medical history and indicated any changes to date on the line provide:

Medical/Dental History Changes

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____ ____________________________
Signature of Client/Parent or Guardian Date

____ ____________________________
Signature of Dental Hygiene Student Date

____ ____________________________
Signature of Dental Hygiene Faculty Date

Medical/Dental History Changes

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____ ____________________________
Signature of Client/Parent or Guardian Date

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Signature of Dental Hygiene Student Date

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Signature of Dental Hygiene Faculty Date

Medical/Dental History Changes

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Medical/Dental History Changes

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Signature of Dental Hygiene Faculty Date

Medical/Dental History Changes

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Signature of Client/Parent or Guardian — Date

Signature of Dental Hygiene Student — Date

Signature of Dental Hygiene Faculty — Date

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