NHTI – CONCORD'S COMMUNITY COLLEGE
CLIENT MEDICAL/DENTAL HISTORY FORM

All information provided is considered confidential and vital for dental care at NHTI - Concord's Community College.

Client Name: _____ **Birth Date**: _____
Last First MI

Address: _____ _____ _____ _____
Street City State Zip Code

_____ Email Address: _____
Occupation

Phone (Home):_____ **(Work):** _____ Ext_____ **(Cell):** _____

_____ _____ _____ _____
Emergency Contact **Relationship** **Home Phone** **Business/Cell Phone**

DENTAL INFORMATION

Do you wear dentures or partials?	YES	NO	Have you had any oral surgery /implants?	YES	NO
Have you had periodontal treatment?	YES	NO	Any serious injury to your head or mouth?	YES	NO
Have you had orthodontic treatment?	YES	NO	Are you experiencing any dental pain today?	YES	NO
Do you have a TMJ Disorder?	YES	NO	Fluoridated water/Supplement	YES	NO
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?				YES	NO

Dentist Name: _____ **Phone Number:** _____
Address:_____**ZIP Code:** _____
Date of last dental exam: _____ **Date of last cleaning:** _____
Date of last bitewing radiographs: _____ **Date of last full mouth series of radiographs:** _____

MEDICAL INFORMATION

Physician's Name:_____ **Phone: ( )** _____

Address: _____ **City/State/Zip** _____

Are you under the care of a physician? YES NO **Date of last physical exam:** _____
Have you had a serious illness, operation or been hospitalized in the past 5 years? YES NO
Has there been any change in your general health within the past year or are you being treated for a condition now? YES NO
If yes, explain: _____

***Please circle if you are allergic to the following:**

Local anesthetics **Aspirin** **Penicillin or other antibiotics** **Latex** **Foods**
Barbiturates, Sedatives **Sulfa drug** **Codeine or other narcotics** **Other:** _____
Describe Reaction: _____

PRESCRIPTION or NON PRESCRIPTION or HERBAL MEDICATIONS

List all medications and herbal supplements/remedies that you are currently taking.

NAME	DOSE	NAME	DOSE	NAME	DOSE

Are you taking or have taken any diet drugs such as Pondimin, Redux or Phen-fen? YES NO
Are you taking or scheduled to begin taking either of the medications Fosamax or Actonel? YES NO
Since 2001, were you treated or are you scheduled to begin treatment with the intravenous bisphosphates (Aredia or Zometa) for bone pain, hypocalcaemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? YES NO

Please circle Yes or No (Y or N) for any illnesses that you CURRENTY HAVE OR HAVE HAD IN THE PAST.

HEART/BLOOD DISORDERS			OTHER CONDITIONS			IMMUNE SYSTEM DISORDERS		
*Artificial Heart Valves	Y	N	*Kidney Problems/Dialysis	Y	N	Systemic Lupus	Y	N
*Congenital Heart Defects	Y	N	Liver Disease	Y	N	Rheumatoid Arthritis	Y	N
Heart Murmurs	Y	N	*Artificial Joints	Y	N	Sjogren's Syndrome	Y	N
*Angina	Y	N	Type:			Allergies	Y	N
Congestive Heart Failure	Y	N	Cancer/Chemotherapy/Radiation	Y	N	OTHER:		
*Heart Surgery	Y	N	Persistent Swollen Glands	Y	N			
*Heart Attack	Y	N	Osteoporosis	Y	N	**BEHAVIORAL CONDITIONS/HABITS**		
*Prosthetic Heart Valve	Y	N	Chronic Pain	Y	N	Mental Health Disorder	Y	N
Pacemaker/Defib	Y	N	Pregnancy/Nursing	Y	N	Anxiety/Panic Attacks	Y	N
*Bacterial Endocarditis	Y	N	Due Date:			Controlled Substance Use	Y	N
Coronary Artery Disease	Y	N	OTHER:			What?		
*High Blood Pressure	Y	N	**INFECTIOUS DISEASES**			Alcohol Use	Y	N
Abnormal Bleeding	Y	N	AIDS/HIV	Y	N	Amount per week:		
Hemophilia	Y	N	Hepatitis	Y	N	Tobacco Use	Y	N
Anemia	Y	N	Sexually transmitted disease	Y	N	Type:		
OTHER:			OTHER:			Amount per day:		
						Interested in Stopping	Y	N
RESPIRATORY/LUNG CONDITIONS			**GASTROINTESTINAL DISORDERS**			OTHER:		
*Asthma	Y	N	G.E. Reflux/Heartburn	Y	N			
*Emphysema/COPD	Y	N	Ulcers/Gastritis	Y	N	**HORMONAL OR METABOLIC DISORDERS**		
Bronchitis	Y	N	Eating Disorder	Y	N			
Do you have any of the following diseases or problems? IF YES, STOP , PLEASE SEE BELOW			Inflammatory Bowel Disease	Y	N			
			NEUROLOGICAL DISORDERS			Diabetes, Type I or II	Y	N
History of Tuberculosis?	Y	N				Thyroid Problem	Y	N
*Active Tuberculosis?	Y	N	Epilepsy	Y	N	OTHER:		
Persistent cough greater then a 3 week duration?	Y	N	*Stroke	Y	N			
Cough that produces blood?	Y	N	Migraine	Y	N			
Been exposed to anyone with Tuberculosis?	Y	N	OTHER:					
If you have answered yes to any of these 4 questions above, please stop and return this form to the receptionist.								

Additional Comments:

_____

_____

_____

_____

Do you have any disease, condition or problem not listed above that you think we should know about?

_____

_____

To the best of my knowledge, the above information is complete and correct.

_____ **Date:** _____

Signature **Print Name**

If you are completing this form for another person, what is your name and relationship to the patient?

Name: _____ **Relationship**_____

Revised 9/10/2010

PROGRESS NOTES **CLIENT:** ____

DATE	NARRATIVE	STUDENT	FACULTY

PROGRESS NOTES **CLIENT:** ______________________________

DATE	NARRATIVE	STUDENT	FACULTY