PT ID#

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Salt Lake Community College

DENTAL/MEDICAL HISTORY FORM

SLCC has written policies on this clipboard to protect your privacy. Please read them and if you have any questions please ask. The Dental/Medical History Form should be answered completely and as accurately as possible. The information will allow us to provide appropriate care for you. Thank you for being a patient in our student dental hygiene clinic.

PLEASE FILL OUT THIS FORM COMPLETELY

Last Name: _____First name: _____Middle Initial: _____ Male ☐ Female ☐ Other ☐

Street Address: _____City_____State_____ Zip: _____ Date of Birth: _____ m/d/yr

Cell Phone: _____Alternate Phone: _____email: _____

How do you prefer we contact you? _____ Occupation: _____

Emergency contact: _____ Relationship: _____Phone: _____

Dentist Name: _____ City: _____State: _____ Phone: _____

Dental History

	Question	Yes	No		Question	Yes	No
A.	Do your gums bleed when you brush or floss?			K.	Do you experience frequent ulcers in your mouth?		
B.	Are your teeth sensitive to hot, cold, sweets, or pressure?			L.	Do you currently have any sores or ulcers in your mouth?		
C.	Does food or floss catch between your teeth?			M.	Do you participate in energetic sports or activities?		
D.	Is your mouth often dry?			N.	Do you grind your teeth?		
E.	Have you had periodontal (gum) treatment?			O.	Do you wear dentures or partial dentures?		
F.	Have you had orthodontic treatment (braces)?			P.	Is your home water fluoridated?		
G.	Have you had serious injury to your head or mouth?			Q	Do you frequently drink bottled water?		
H.	Do you have clicking, Popping, or other discomfort in your jaw?			R.	Date of your last dental Exam?	/ /	
I.	Have you had any problems related to dental treatment?			S.	Date of your last dental radiographs (x-rays)	/ /	
J.	Are you currently experiencing dental pain or discomfort?					m/d/yr	

What is the reason for your visit today? _____

Medical History

	Question	Yes	No	If Yes, please explain
A.	Are you under a physician's care now?			
B.	Have you ever been hospitalized or had a major operation?			
C	Have you ever had a serious head or neck injury?			
D.	Are you taking any medications, pills, or drugs?			
E.	Do you take, or have you taken, Phen-Fen or Redux?			
F.	Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
G.	Are you on a special diet?			
H.	Do you use any tobacco products?			
I.	Do you use any controlled substances?			
J.	Do you Vape or use E-cigarettes?			
K.	Do you use any forms of Marijuana, Pot, Weed or Cannabis?			
L .	Have you used any tobacco products, controlled substances, vape or any forms or marijuana in the past?			

Medications

Please list any/all prescription and over-the-counter medicines that you are currently taking. Include vitamins, natural medicines, herbal supplements, or remedies. Please include dosages and frequency of use.

Prescription		Over-the-counter	
Name of medication	Dose	Product name	Frequency of use

Do you have, or have you had any of the following?

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS/HIV positive			Cortisone medicine			Hemophilia			Radiation treatment		
Alzheimer's disease			Diabetes			Hepatitis A			Recent weight loss		
Anaphylaxis			Drug addiction			Hepatitis B or C			Renal dialysis		
Anemia			Easily winded			Herpes			Rheumatic fever		
Angina			Emphysema			High blood pressure			Rheumatism		
Arthritis/Gout			Epilepsy or seizures			High cholesterol			Scarlet fever		
Artificial heart valve			Excessive bleeding			Hives or rash			Shingles		
Artificial joint			Excessive thirst			Hypoglycemia			Sickle cell disease		
Asthma			Fainting or dizziness			Irregular heartbeat			Sinus trouble		
Blood disease			Frequent cough			Kidney problems			Spinal bifida		
Blood transfusion			Frequent diarrhea			Leukemia			Stomach/Intestinal disease		
Breathing problems			Frequent headaches			Liver disease			Stroke		
Bruise easily			Genital herpes			Low blood pressure			Swelling of limbs		
Cancer			Glaucoma			Lung disease			Thyroid disease		
Chemotherapy			Hay fever			Mitral valve prolapse			Tonsillitis		
Chest pains			Heart attach/Failure			Osteoporosis			Tuberculosis		
Cold sores/Fever blisters			Heart murmur			Pain in jaw joints			Tumors or growths		
Congenital heart disorder			Heart pacemaker			Parathyroid disease			Ulcers		
Convulsions			Heart trouble/Disease			Psychiatric care			Venereal disease		
Have you ever had any serious illness, or body piercings not listed above?			If Yes, Please explain:_____ _____ _____						Yellow Jaundice		

Additional questions for women.

Question	Yes	No
Are you pregnant or trying to get pregnant?		
Are you taking oral contraceptives?		
Are you nursing?		

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other; please explain: _____

Physicians name: _____City: _____State: _____ Phone: _____

I understand the importance of complete and truthful medical and dental information and that incorrect information could pose a serious threat to my health. To the best of my knowledge the answers to the preceding questions are true and correct. I will not hold Salt Lake community College (SLCC) or any person who provides dental Hygiene or dental services responsible for any actions that they take or do not take because of any errors or omissions that I may have made in the completion of this form. I consent to the release of medical/dental information to my dentist, physician, or other healthcare professional if requested.

Further, if I ever have any change in my health, or if my medications change, I will inform my student dental hygienist or a SLCC faculty member at my next appointment. I hereby grant permission to be treated by students and faculty of SLCC.

_____ _____

Signature of Patient/Legal Guardian *Date*

_____ _____

Signature of Student/Number *Date*

_____ _____

Signature of Clinical Instructor/Number *Date*

Note: Your signature below verifies that any necessary changes to the history for subsequent appointments have been noted and dated on the form. A new dental/medical history form must be completed every three years.

	Date	Patient signature	Patient Vitals	Student	Instructor
a	/ /		BP: P: R:		
b	/ /		BP: P: R:		
c	/ /		BP: P: R:		
d	/ /		BP: P: R:		
e	/ /		BP: P: R:		
f	/ /		BP: P: R:		
g	/ /		BP: P: R:		

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