Time 3:37 PM

Laramie County Community College

Date 7/2/2015

Dental Hygiene Medical/Dental History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you are taking, may have an interrelationship with the dental treatment you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes No	If yes
History of hospitalization or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	If yes
Do you use tobacco?	Yes No	
Have you ever been pre-medicated for your previous dental treatment?	Yes No	If yes
Have you had any serious trouble associated with previous dental treatment?	Yes No	If yes
When was your last dental visit?		omment

Women: Are you...

- Pregnant/Trying to get pregnant
- Nursing
- Taking oral contraceptives/HRT
- Menopausal

Are you allergic to any of the following?

- Aspirin
- Penicillin
- Codeine
- Acrylic
- Metal
- Latex
- Sulfa Drugs
- Local Anesthetics

OtherAllergy?		If yes
Do you use alcohol/controlled substances?	Yes No	If yes

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

AIDS/HIV Positive Yes No	Diabetes Yes No	Hemophilla Yes No	Radiation Treatments Yes No
Alzheimer's/Dementia Yes No	Drug Addiction Yes No	Hepatitis A Yes No	Recent Weight Loss Yes No
Anaphylaxis Yes No	Easily Winded Yes No	Hepatitis B or C Yes No	Renal Dialysis Yes No
Anemia Yes No	Eating Disorder Yes No	Herpes Yes No	Rheumatic Fever Yes No
Angina Yes No	Emphysema Yes No	High Blood Pressure Yes No	Rheumatism Yes No
Arthritis/Gout Yes No	Epilepsy or Seizures Yes No	High Cholesterol Yes No	Scarlet Fever Yes No
Artificial Heart Valve Yes No	Excessive Bleeding Yes No	Hives or Rash Yes No	Shingles Yes No
Artificial Joint Yes No	Excessive Thirst Yes No	Hypoglycemia Yes No	Sickle Cell Disease Yes No
Asthma Yes No	Fainting Spells/Dizziness Yes No	Irregular Heartbeat Yes No	Sinus Trouble Yes No
Blood Disease Yes No	Frequent Cough Yes No	Kidney Problems Yes No	Spina Bifida Yes No
Blood Transfusion Yes No	Frequent Diarrhea Yes No	Leukemia Yes No	Stomach/Intestinal Disease Yes No
Breathing Problems Yes No	Frequent Headaches Yes No	Liver Disease Yes No	Stroke Yes No
Bruise Easily Yes No	Genital Herpes Yes No	Low Blood Pressure Yes No	Swelling of Limbs Yes No
Cancer Yes No	Glaucoma Yes No	Lung Disease Yes No	Thyroid Disease Yes No
Chemotherapy Yes No	Hay Fever Yes No	Mitral Valve Prolapse Yes No	Tonsillitis Yes No
Chest Pains Yes No	Hearing Loss Yes No	Numbness/Tingling Yes No	Tuberculosis Yes No
Cold Sores/Fever Blisters Yes No	Heart Attack/Failure Yes No	Osteoporosis Yes No	Tumors or Growths Yes No
Congenital Heart Disease Yes No	Heart Mumur Yes No	Pain in Jaw Joints Yes No	Ulcers Yes No
Convulsions Yes No	Heart Pace Maker Yes No	Parathyroid Disease Yes No	Veneral Disease/HPV Yes No
Cortisone Medicine Yes No	Heart Trouble/Disease Yes No	Psychiatric Care Yes No	Yellow Jaundice Yes No

Have you ever had any serious illness not listed	Yes No	If yes
In case of emergency notify (include phone#):		omment
FOR OFFICE USE ONLY: Pre-Med Required		

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X_____ Date:_____

Signature of Supervising Dentist/Faculty:

X_____ Date:_____