Date ______________________

WCTC Dental Hygiene Clinic
MEDICAL HISTORY FORM

Name ____________________ _______________ ______ Address____
Last First Middle Number, Street

City ____________________ State __________ Zip Code __________ Home # _____________ Work # ____________

Birthdate _______________ Gender ______ Single ______ Married ______

Emergency Contact: ____________________________________ Telephone # ___________________________

If you are completing this form for another person, what is your relationship to that person? ____________________________

Ethnicity: _ American Indian or Alaskan Native _Asian or Pacific Islander _Black/Non-Hispanic

_Hispanic _ White/Non-Hispanic _Middle Eastern _ Other

Are you now or have you ever been under a physician's care for any of the following conditions? If Yes, please indicate which condition(s) from the list below.

☐ *Med. Compromised ☐ Allergies ☐ Allergy: Codeine ☐ Allergy: Latex ☐ Allergy: Penicillin

☐ Anemia ☐ Art. Heart Valve ☐ Arthritis ☐ Artificial Joints ☐ Asthma ☐ Back Problems

☐ Blood Disease ☐ Cancer ☐ Chemical Dependency ☐ Chemotherapy ☐ Circulatory Problems

☐ Cortisone Treatment ☐ Cough Persistant ☐ Diabetes ☐ Dizziness ☐ Epilepsy ☐ Excessive Bleeding

☐ Fainting ☐ Glaucoma ☐ Growths/Tumors ☐ Hay Fever ☐ Head Injuries ☐ Headaches

☐ Heart Problems ☐ Hemophilia ☐ Hepatitis ☐ High Blood Pressure ☐ HIV ☐ Jaw Pain

☐ Kidney Disease ☐ Liver Disease ☐ Mental Disorders ☐ Nervous Disorders ☐ Osteoporosis

☐ Pacemaker ☐ Pregnancy (w/in 1yr) ☐ PREMED ☐ Radiation Treatment ☐ Respiratory Problems

☐ Rheumatic Fever ☐ Scarlet Fever ☐ Shortness of Breath ☐ Sinus Problems ☐ Skin Rash

☐ Stomach Issues/GERD ☐ Stroke ☐ Swelling of Feet ☐ Thyroid Problems ☐ Tobacco Habit

☐ Tonsillitis ☐ Tuberculosis ☐ Venereal Disease ☐ x: OTHER ______________________________

Please list any condition you have that is not listed above or any additional information.
____

Please list your current primary Physician's/Specialist's names & phone numbers:

____

Have you ever been hospitalized, had an operation or a serious illness? ○ Yes ○ No

If Yes, please explain:____

Do you now or have you ever required pre-medication for dental treatment? If yes, please explain below:

____

Are you allergic to any of the following? Check all that apply

☐ Aspirin ☐ Penicillin ☐ Codeine or other narcotics ☐ Acrylic ☐ Metals ☐ Latex ☐ Local Anesthetic

☐ Sulfa Drugs ☐ Iodine ☐ Red Dye ☐ Tree Nuts ☐ Other

If you checked yes, please describe the reaction(s):____

Do you use any of the following?

☐ Cigarette Smoker ☐ Vapor Cigarettes ☐ Cigar Smoker ☐ Smokeless/Chewing Tobacco ☐ Hookah ☐ Marijuana

If selected from list above, how often are you using these products? ____

Are you pregnant or nursing? ○ Yes ○ No

Please list any prescription medications, over-the-counter medications, vitamins/minerals or herbal remedies you are taking. Please include dosage and REASON for each.

____
____
____
____

Please answer the following questions regarding your dental history.

At the present time, do you have any dental concerns? ○ Yes ○ No

If yes, please describe: ____

Dentist's Name, Phone Number & Email:

____

When was the approximate date of your last dental exam? _______________________

When was your last dental cleaning? _________________

When was the last time you had dental x-rays? __________________

How often do you usually visit your dentist? ____________________

Have you ever been treated for periodontal/gum disease? ○ Yes ○ No

Do you have any dental implants? ○ Yes ○ No

Have you had any serious trouble associated with any previous dental visit? ◯ Yes ◯ No

If so, please explain.____

Have you ever had local anesthetic? ◯ Yes ◯ No

If you have, did you have any reactions or symptoms from local anesthetic? ◯ Yes ◯ No

If so, please explain.____

Do you have any pain in or near your ears? ◯ Yes ◯ No

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

☐ Cold Sore/Fever Blister ☐ Canker Sore ☐ Unhealed Mouth Sore

Please check any of the following oral habits that you have:

☐ Grinding your teeth ☐ Clenching your teeth ☐ Mouth breathing ☐ Nail biting ☐ Thumb sucking/Pacifiers

☐ Chewing on pens, pencils, bobby pins, other objects ☐ Other

Explain: ____

Do you now or have you ever lived in an area with fluoridated water? ◯ Yes ◯ No If so, what ages?________________

Which dental products/items do you use regularly at home?

____

Do you snack during the day? ◯ Yes ◯ No

What do you usually snack on?____

Do you consume any of the following?

☐ Candy/Chocolates ☐ Gum ☐ Mints ☐ Cough Drops ☐ Soda ☐ Sports Drinks ☐ Energy Drinks

☐ Coffee/Tea with cream or sugar

How often do you consume them? ____