



**LAKESHORE**  
TECHNICAL COLLEGE

**DENTAL ASSISTANT STUDENT  
MEDICAL/DENTAL HISTORY**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
           Last                                      First                                      M.I.

Address \_\_\_\_\_  
                                   Street    City    Zip

MEDICAL ALERT \_\_\_\_\_

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_

Approximate date of last physical examination \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you under any medical treatment now? .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had any major operations? If so what? .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious accident involving head injuries?.....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you had any adverse response to any drugs including penicillin?.....          | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has a physician ever informed you that you had: a heart ailment?.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.                                      high blood pressure?.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 7.                                      respiratory disease?.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.                                      diabetes?.....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.                                      rheumatic fever?.....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| 10.                                     rheumatism or arthritis?.....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.                                    tumors or growths?.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 12.                                    any blood disease?.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 13.                                    any kidney disease?.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.                                    any stomach or intestinal disease?.....        | <input type="checkbox"/> | <input type="checkbox"/> |
| 15.                                    any venereal disease?.....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 16.                                    yellow jaundice or hepatitis?.....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 17.                                    heart murmurs?.....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 18.                                    joint replacements?.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have night sweats accompanied by weight loss or cough? .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Are you on a diet at this time? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Are you now taking drugs or medication? If yes, what? .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Are you allergic to any known materials resulting in hives, asthma, eczema, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Are you in generally good health at this time? .....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Have any wounds healed slowly or presented other complications?.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. ARE YOU PREGNANT? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Do you have a history of fainting?.....   | <input type="checkbox"/> | <input type="checkbox"/> |

27. Have you ever had any radiation treatments (other than diagnostic)?.....

**DENTAL HISTORY**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 28. Do you have pain in or near your ears?.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Do you have any unhealed injuries or inflamed areas in<br>or around your mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Have you experienced any growth or sore spots in your mouth?.....                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Does any part of your mouth hurt when clenched? .....                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Have you ever had Novocaine anesthetic? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 33.                   Any reactions or allergic symptoms to Novocaine? .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| 34.                   Any difficult extractions in the past?.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 35.                   Prolonged bleeding following extractions in the past?.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| 36.                   Trench mouth? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Do your gums bleed? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 38. Have you ever had instruction on the correct method of brushing your teeth?.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Have you ever had instructions on the care of your gums?.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 40. Do you chew on only one side of your mouth? If so, why? .....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 41. Do you at the present time have any dental complaints?.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 42. Do you habitually clench your teeth during the night or day? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? .....    | <input type="checkbox"/> | <input type="checkbox"/> |

44. When was your last complete set of x-rays taken? \_\_\_\_\_ Where? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date \_\_\_\_\_

**Please fill out the information below, obtain your dentist’s signature, and return to Admission Office.**

Dentist Name (print): \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

Office Phone: \_\_\_\_\_

As a Dental Assistant program student at LTC, the following procedures may be performed on  
(print your name) \_\_\_\_\_

Radiographs

Coronal Polishing

Fluoride Treatment

Bleaching

Alginate Impressions

Dentist’s Signature: \_\_\_\_\_



**1290 North Avenue, Cleveland, WI 53015**

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