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? ………………………………………..	☐	☐
2.	Have you had any major operations? If so what? …………………………………	☐	☐
3.	Have you ever had a serious accident involving head injuries?...............................	☐	☐
4.	Have you had any adverse response to any drugs including penicillin?..................	☐	☐
5.	Has a physician ever informed you that you had: a heart ailment?..........................	☐	☐
6.	high blood pressure?..	☐	☐
7.	respiratory disease?..	☐	☐
8.	diabetes?..	☐	☐
9.	rheumatic fever?...	☐	☐
10.	rheumatism or arthritis?..	☐	☐
11.	tumors or growths?..	☐	☐
12.	any blood disease?...	☐	☐
13.	any kidney disease?..	☐	☐
14.	any stomach or intestinal disease?................................	☐	☐
15.	any venereal disease?..	☐	☐
16.	yellow jaundice or hepatitis?...	☐	☐
17.	heart murmurs?...	☐	☐
18.	joint replacements?...	☐	☐
19.	Do you have night sweats accompanied by weight loss or cough? ………………..	☐	☐
20.	Are you on a diet at this time?	☐	☐
21.	Are you now taking drugs or medication? If yes, what?	☐	☐
22.	Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?	☐	☐
23.	Are you in generally good health at this time?	☐	☐
24.	Have any wounds healed slowly or presented other complications?.........................	☐	☐
25.	ARE YOU PREGNANT?	☐	☐
26.	Do you have a history of fainting?...	☐	☐

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?...	☐	☐
29.	Do you have any unhealed injuries or inflamed areas in or around your mouth?..	☐	☐
30.	Have you experienced any growth or sore spots in your mouth?............................	☐	☐
31.	Does any part of your mouth hurt when clenched?	☐	☐
32.	Have you ever had Novocaine anesthetic?	☐	☐
33.	Any reactions or allergic symptoms to Novocaine?	☐	☐
34.	Any difficult extractions in the past?...	☐	☐
35.	Prolonged bleeding following extractions in the past?...............	☐	☐
36.	Trench mouth?	☐	☐
37.	Do your gums bleed?	☐	☐
38.	Have you ever had instruction on the correct method of brushing your teeth?.........	☐	☐
39.	Have you ever had instructions on the care of your gums?......................................	☐	☐
40.	Do you chew on only one side of your mouth? If so, why?	☐	☐
41.	Do you at the present time have any dental complaints?..	☐	☐
42.	Do you habitually clench your teeth during the night or day?	☐	☐
43.	Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)?	☐	☐

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