Medical Alert - Condition:	Premedication:	Allergies:	Anesthesia:	Date:

JCCC Dental Hygiene OHOW Clinic
Health History Form

CONTACT INFORMATION

Name: LAST FIRST MIDDLE

Contact Phone: ( )

Address: P.O. Box or Mailing Address City: State: ZIP:

Date of Birth: Sex: M ❑ F ❑

Emergency Contact: Relationship: Phone: ( )

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

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

MEDICAL INFORMATION

If you answer yes to any of the 4 items below, please stop and return this form to the receptionist.

Have you had any of the following diseases or problems?	Yes	No	Don't Know
Active Tuberculosis	❑	❑	❑
Persistent cough greater than a 3-week duration	❑	❑	❑
Cough that produces blood	❑	❑	❑
Active Hepatitis	❑	❑	❑

	Yes	No	Don't Know
1. Are you in good health?	❑	❑	❑
2. Has there been any change in your general health within the past year?	❑	❑	❑
3. Are you now under the care of a physician? If yes, what is/are the condition(s) being treated? _____	❑	❑	❑
Date of last physical examination: _____			
4. Have you had any serious illness, operation, or been hospitalized in the past 5 years? If yes, what was the illness or problem? _____	❑	❑	❑
Are you taking or have you recently taken (past 6 months) any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking?	❑	❑	❑

5. Prescribed: _____

6. Over-the-counter: _____

7. Vitamins, natural or herbal preparations and/or diet supplements: _____

8. Are you taking or have you taken steroids (cortisone) within the past 2 years? ❑ ❑ ❑
If so, explain: _____

	Yes	No	Don't Know
9. Are you taking or have you taken any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?	❑	❑	❑
10. Do you use tobacco (smoking, snuff, chew)? If yes, how interested are you in stopping? (circle one) Very / Somewhat / Not interested	❑	❑	❑
11. Are you allergic to or have you had a reaction to:			
Local anesthetics	❑	❑	❑
Aspirin	❑	❑	❑
Penicillin or other antibiotics	❑	❑	❑
Barbiturates, sedatives or sleeping pills	❑	❑	❑
Sulfa drugs	❑	❑	❑
Codeine or other narcotics	❑	❑	❑
Latex	❑	❑	❑
Iodine	❑	❑	❑
Hay fever/seasonal allergies	❑	❑	❑
Animals	❑	❑	❑
Food (specify) _____	❑	❑	❑
Metals (specify) _____	❑	❑	❑
Other (specify) _____	❑	❑	❑

To yes responses, specify type of reaction. _____

12. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? If yes, when was this operation done? _____ ❑ ❑ ❑

If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint?

	Yes	No	Don't Know
13. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? If yes, what antibiotic and dose? _____ Name of physician or dentist: _____ Phone: _____	❑	❑	❑

WOMEN ONLY	Yes	No	Don't Know
14. Are you or could you be pregnant?	❑	❑	❑
15. Are you nursing?	❑	❑	❑
16. Are you taking birth control pills or hormonal replacement?	❑	❑	❑

Please (X) a response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	Don't Know
17. Abnormal bleeding	❑	❑	❑
18. AIDS or HIV infection	❑	❑	❑
19. Anemia	❑	❑	❑
20. Arthritis	❑	❑	❑
21. Rheumatoid arthritis	❑	❑	❑
22. Asthma	❑	❑	❑
23. Blood transfusion. If yes, date: _____	❑	❑	❑
24. Cancer/chemotherapy/radiation treatment	❑	❑	❑
25. Cardiovascular disease. If yes, specify below:	❑	❑	❑

___ Angina
___ Arteriosclerosis
___ Artificial heart valves
___ Congenital heart defects
___ Congestive heart failure
___ Coronary artery disease
___ Damaged heart valves
___ Heart attack: year ____
___ Heart murmur
___ High blood pressure
___ Low blood pressure
___ Mitral valve prolapse
___ Pacemaker: year _____
___ Rheumatic heart disease/rheumatic fever
___ Irregular heartbeat

26. Chest pain upon exertion	❑	❑	❑
27. Chronic pain: location _____	❑	❑	❑
28. Disease, drug or radiation-induced immunosuppression	❑	❑	❑
29. Diabetes. If yes, specify below: ___ Type I (Insulin dependent) ___ Type II	❑	❑	❑
30. Dry mouth	❑	❑	❑
31. Epilepsy	❑	❑	❑
32. Fainting spells or seizures	❑	❑	❑
33. Gastrointestinal disease If yes, specify: _____	❑	❑	❑
34. G.E. reflux/persistent heartburn	❑	❑	❑
35. Glaucoma	❑	❑	❑
36. Hearing disorder	❑	❑	❑
37. Hemophilia	❑	❑	❑
38. Hepatitis, jaundice or liver disease	❑	❑	❑
39. Hypoglycemia	❑	❑	❑
40. Recurrent infections. If yes, indicate type of infection: _____	❑	❑	❑
41. Kidney problems	❑	❑	❑

	Yes	No	Don't Know
42. Mental health disorders. If yes, specify: _____	❑	❑	❑
43. Malnutrition	❑	❑	❑
44. Neurological disorders If yes, specify: _____	❑	❑	❑
45. Persistent swollen glands in neck	❑	❑	❑
46. Respiratory problems. If yes, specify below:	❑	❑	❑

___ Emphysema ___ Bronchitis
___ Shortness of breath ___ Other _____

47. Sexually transmitted disease	❑	❑	❑
48. Sores or ulcers in the mouth	❑	❑	❑
49. Stroke	❑	❑	❑
50. Systemic lupus erythematosus	❑	❑	❑
51. Tuberculosis: year _____ Tx completed _____	❑	❑	❑
52. Do you have any disease, condition or problem not listed above that you think we should know about? Please explain: _____	❑	❑	❑

PATIENT INFORMATION

The primary purpose of the Dental Hygiene Clinic at Johnson County Community College is to provide educational experiences necessary to prepare students for the practice of Dental Hygiene. Primary preventive treatment, including a thorough review of the patient's medical and dental health history, oral examination and recording of oral condition, diet consultation, oral prophylaxis (cleaning), oral radiographs, application of decay preventing agents, and instruction in achieving and maintaining personal oral hygiene, will be provided. Patients in need of further treatment will be referred to their own dentist.

All treatment is provided by Dental Hygiene students under the supervision of licensed dentists and dental hygienists. Treatment provided by students under supervision requires longer appointments and/or multiple visits, and moderate fees defray only some of the operating costs. Dental Hygiene faculty are available to answer questions or discuss concerns.

It is sometimes desirable to photograph, videotape, record, copy or publish treatment procedures for education or research purposes. It is understood that the patient involved is not identified.

In the case of minor or non-English-speaking patients, it is imperative that a parent or legal guardian (at least 18 years of age) accompany the dependent and remain in the reception room during all procedures.

Patients are expected to be on time for their appointments. Patients who are more than 15 minutes late for an appointment may have treatment deferred to another appointed time. Chronic tardiness or failure to keep appointments may be grounds for inactivation of the patient.

PATIENT OR GUARDIAN CONSENT OR RELEASE

I have read, understand and agree to abide by the above Patient Information. I hereby consent to care and treatment for (myself) (my dependent) by Dental Hygiene students at the Johnson County Community College Dental Hygiene Clinic. I understand that the persons performing such care and treatment are students and are not licensed or qualified to practice dentistry or dental hygiene, that such students will be supervised by licensed or qualified dentists or dental hygiene professors, and that the primary purpose of the Dental Hygiene Clinic is to provide an educational experience for such students as they provide care and treatment of patients. In cooperation with and furtherance of the primary purpose of the Dental Hygiene Clinic, I hereby consent to any and all care and treatment normally performed by students or other personnel at said Clinic, including, but not limited to, examination, diagnosis, treatment, administering of drugs or medication, and the use of X-rays or radiographs.

I hereby further consent to and waive all rights to the making and/or using of all photographs, motion pictures, closed circuit television, television recording, sound recording, artist's illustrations and plastic moldings of any part of my mouth for professional, educational, scientific or research purposes, or for publication or republication for professional, educational, scientific or research purposes.

In consideration of the care and treatment provided to (me) (my dependent) at said Clinic and the moderate fee charged by said Clinic, I hereby covenant and agree NOT TO SUE Johnson County Community College, and its officers, agents, servants, employees and/or students because of any injuries suffered while participating, preparing to participate, or otherwise engaged in activities connected with said Clinic. The undersigned further agrees and covenants to hold Johnson County Community College, its officers, agents, servants, employees and students free and harmless from any and all liability for injury suffered as a result of care or treatment at said Dental Hygiene Clinic. The consents and releases herein shall be considered by all parties hereto as continuing.

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold JCCC employees or students responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT/LEGAL GUARDIAN _____ DATE _____

FOR COMPLETION BY JCCC

The undersigned as witnesses attest to the fact that the aforegoing program patient information statement was given to the person signing above who executed the foregoing statement of information and release in our presence, acknowledging the signature to be a genuine signature of such person and further acknowledging full understanding of the fact that a release was being made.

Dental Hygiene Student Signature _____ Date _____

Dental Hygiene Faculty Signature _____ Date _____

Comments on patient interview concern health history form:

Date	B.P.	Pulse	Change(s) in Health Status	INITIALS Student	Faculty	Patient
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TREATMENT (ATC) ALTERATION TO CARE SUMMARY LOG			
Date	Drug Name/ Dosage/How Often Taken & Why	Medical Consult Y/N	Drug Category, Drug Interactions Adverse Reactions, ATC Information