Rowan College at Burlington County

Health History Form

For office use only:
Adhere medical alert sticker here if applicable
BP: _____/_____ P: _____

Date: ____/____/____

Patient's Name: _____ **Preferred Name:** _____
Last First Middle Initial

Preferred Pronoun (circle): He/Him She/Her They/Them **Date of Birth:** _____ **Age:** _____

Address: _____
Street City State Zip

Phone: ( ) _____ **Type (circle):** Home Cell Work **Email:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

	YES	NO	DK
Have you had any of the following diseases or problems?.....	☐	☐	☐

1. Active Tuberculosis, 2. Persistent cough greater than 3 week duration, 3. Cough that produces blood, 4. Exposed to someone with tuberculosis?

If you answered yes to any of the above 4 questions, please stop and return this form to the receptionist.

DENTAL INFORMATION- *Please mark your responses to the following questions*

	YES	NO	DK
Do your gums bleed when you brush or floss?..	☐	☐	☐
Are your teeth sensitive to cold, hot or sweets?.	☐	☐	☐
Does food or floss catch between your teeth?...	☐	☐	☐
Is your mouth dry?.....	☐	☐	☐
Have you had periodontal/gum treatments?.....	☐	☐	☐
Have you had orthodontic (braces) treatment?..	☐	☐	☐
Have you had any problems associated with previous dental treatment?.....	☐	☐	☐
Is your home water supply fluoridated?.....	☐	☐	☐
Do you drink bottled or filtered water?.....	☐	☐	☐

If so, how often? (circle one) Daily Weekly Occasionally

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

	YES	NO	DK
Are you currently experiencing dental pain or discomfort?..	☐	☐	☐
Do you have earaches or neck pains?.....	☐	☐	☐
Do you have any popping or discomfort in the jaw?.....	☐	☐	☐
Do you brux or grind your teeth?.....	☐	☐	☐
Do you have sores or ulcers in your mouth?.....	☐	☐	☐
Do you wear dentures or partials?.....	☐	☐	☐
Do you participate in recreational activities?.....	☐	☐	☐
Have you ever had a serious injury to your head or mouth?.	☐	☐	☐

DENTAL APPOINTMENT HISTORY

Date of your last dental exam: ____/____/____

What was done? _____

Date of last dental x-rays: ____/____/____

Dentist name and contact information: _____

MEDICAL INFORMATION- *Please mark your response to the following questions*

	YES	NO	DK
Are you now in the care of a physician?.....	☐	☐	☐
Are you in good health?.....	☐	☐	☐
Has there been any change in your general health within the past year?.....	☐	☐	☐

Physician's name: _____

Phone number: _____

Address: _____

City/State/Zip: _____

If yes, what condition is being treated? _____

Date of your last physical exam? ____/____/____

	YES	NO	DK
Have you had a serious illness, operation or been hospitalized in the last 5 years?.....	☐	☐	☐
Are you taking any prescription or over the counter medications?.....	☐	☐	☐

If yes, what was the illness or problem? _____

If yes, please list them all, including vitamins, natural supplements:

_____ _____

_____ _____

_____ _____

_____ _____

Please complete both sides of this form.

	YES	NO	DK
Do you wear contact lenses?	☐	☐	☐

JOINT REPLACEMENT:

	YES	NO	DK
Have you had and orthopedic joint replacement (hip, knee, elbow, or finger) replacement?	☐	☐	☐
Date of replacement: ____/____/____			
If yes, have you had any complications?	☐	☐	☐
Are you taking or scheduled to start taking any medications for osteoporosis?	☐	☐	☐

	YES	NO	DK
Have you ever been treated with intravenous bisphosphonates (Reclast, Aredia, Boniva) for bone pain, hypercalcemia, Paget's disease, multiple myeloma, or metastatic cancer?	☐	☐	☐
Date treatment began: ____/____/____			
Do you use recreational drugs?	☐	☐	☐
What is your weekly alcohol consumption? _____ drinks/ week			
Do you smoke (cigarettes, cigars, marijuana, vape, hookah) or use smokeless tobacco?	☐	☐	☐
If yes, are you interested in quitting?	☐	☐	☐

WOMEN ONLY:	YES	NO	NA
Are you pregnant?	☐	☐	☐
If yes, how many weeks? _____			

	YES	NO	NA
Are you taking birth control or hormonal replacement?.	☐	☐	☐
Are you nursing?	☐	☐	☐

ALLERGIES: Are you allergic to or have you had a reaction to any of the following? ***If yes, please specify the type of reaction you had.***

	YES	NO	DK
Local anesthetics	☐	☐	☐
Aspirin	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐
Codeine or other narcotics	☐	☐	☐
Other medication(s)- please specify	☐	☐	☐

	YES	NO	DK
Metals	☐	☐	☐
Latex	☐	☐	☐
Seasonal allergies	☐	☐	☐
Food	☐	☐	☐
Any other allergy- please specify	☐	☐	☐

The following conditions require antibiotic prophylaxis prior to dental treatment	YES	NO	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous history of infective endocarditis	☐	☐	☐
Damaged heart valves in a transplanted heart	☐	☐	☐
CONGENITAL HEART DISEASE (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired completely in the last 6 months	☐	☐	☐
Repaired CHD with residual effect	☐	☐	☐

	YES	NO	DK
Cardiovascular disease	☐	☐	☐
Heart Attack	☐	☐	☐
If yes, date: _____			
Angina/ Chest Pain	☐	☐	☐
Congestive heart failure	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Congenital heart defects	☐	☐	☐

	YES	NO	DK
Pacemaker	☐	☐	☐
If yes, year placed: _____			
Damaged heart valves	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Rheumatic fever or heart disease	☐	☐	☐
Type I Diabetes	☐	☐	☐
Type II Diabetes	☐	☐	☐
Cancer	☐	☐	☐
Chemotherapy/ Radiation	☐	☐	☐

	YES	NO	DK
Stroke	☐	☐	☐
If yes, date: _____			
Neurological disorder	☐	☐	☐
Epilepsy/seizures	☐	☐	☐
Fainting spells	☐	☐	☐
Asthma	☐	☐	☐
Emphysema/COPD	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Tuberculosis	☐	☐	☐
Sinus trouble	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
GERD/Reflux/Heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid Problems	☐	☐	☐
Autoimmune disease	☐	☐	☐
Arthritis	☐	☐	☐
Chronic pain	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐

	YES	NO	DK
Osteoporosis	☐	☐	☐
Glaucoma	☐	☐	☐
Night sweats	☐	☐	☐
Kidney problems	☐	☐	☐
Excessive urination	☐	☐	☐
Sleep disorder	☐	☐	☐
Mental health disorder	☐	☐	☐
If yes: specify: _____			
Eating disorder	☐	☐	☐
Cold sores	☐	☐	☐
Severe migraines	☐	☐	☐
Hepatitis/liver disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Blood disorders	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
HIV or AIDS	☐	☐	☐
Sexually transmitted disease	☐	☐	☐

	YES	NO	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐
If yes, please explain: _____			
Do you have any disease, condition, or problem not listed above?	☐	☐	☐
If yes, please explain: _____			

NOTE: Both dental team and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above, and that the information given on this form is accurate. I understand the importance of a truthful health history and that RCBC staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold RCBC or any other member of the staff 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: _____

Student Signature: _____ Date: _____

Instructor Signature: _____ Date: _____