

# NWTC DEPARTMENT OF DENTAL HYGIENE CONFIDENTIAL CLIENT HEALTH RECORD

**Office Use Only**  
 HIPAA on File \_\_\_\_\_  
 Appointment date \_\_\_\_\_  
 File # \_\_\_\_\_

**PLEASE USE BLACK OR BLUE INK**

Client's Full Name: \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_ Occupation: \_\_\_\_\_

\*Have you been seen in our clinic under another name? \_\_\_\_\_

Medical Doctor's Name: \_\_\_\_\_ City: \_\_\_\_\_

Date of last medical visit: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Are you under care of a doctor now? \_\_\_\_\_ If yes, why? \_\_\_\_\_

Name of Prescription Medications	Dosage	Date Started	Treatment for	Dental Considerations

See attached medication list

**Please CIRCLE (Yes/No) if YOU have or ever had any of the following:**

- |                                     |   |
|-------------------------------------|---|
| YES NO High or Low Blood Pressure   | YES NO Excessive Thirst                 |
| YES NO Congenital Heart Defect      | YES NO Appetite Suppressant Drugs       |
| YES NO Heart Murmur                 | YES NO Rapid Weight Loss                |
| YES NO Heart Surgery                | YES NO Venereal Disease                 |
| YES NO Artificial Heart Valve       | YES NO Herpes                           |
| YES NO Cardiac Stent                | YES NO HIV Positive                     |
| YES NO Pacemaker                    | YES NO AIDS                             |
| YES NO Heart Disease                | YES NO Cancer or Leukemia               |
| YES NO Heart Attack                 | YES NO Abnormal Bleeding                |
| YES NO Chest Pains                  | YES NO Blood Transfusion                |
| YES NO Rheumatic Fever              | YES NO Radiation Therapy                |
| YES NO Arthritis                    | YES NO Chemotherapy                     |
| YES NO Artificial Joint or Hip      | YES NO Organ Transplant                 |
| YES NO Artificial Pin               | YES NO Stroke                           |
| YES NO Tuberculosis                 | YES NO Epilepsy or Seizures             |
| YES NO Emphysema                    | YES NO Headaches                        |
| YES NO Asthma                       | YES NO Allergies to Drug or Medications |
| YES NO Sinus Trouble                | YES NO Allergy to Penicillin            |
| YES NO Frequent Cough               | YES NO Latex                            |
| YES NO Liver Disease                | YES NO Other Allergies                  |
| YES NO Hepatitis (Jaundice)         | YES NO Unexplained Fevers               |
| YES NO Spleen Removal               | YES NO Prolonged Sore Throat            |
| YES NO Kidney Problems              | YES NO Swollen Lymph Nodes              |
| YES NO Diabetes                     | YES NO Night Sweats                     |
| YES NO Thyroid Condition            | YES NO Fainting                         |
| YES NO History of Osteoporosis      | YES NO Tobacco Use                      |
| YES NO Bone-loss Drugs in Cancer tx | YES NO Alcohol Use                      |
|                                     | YES NO Cocaine Use                      |

Have you ever had or do you have any other conditions or illnesses not listed above? \_\_\_\_\_

Have you ever had out-patient surgery? \_\_\_\_\_ When & Why? \_\_\_\_\_

Have you ever been hospitalized? \_\_\_\_\_ When & Why? \_\_\_\_\_

**Females:** Are you pregnant? YES NO Due Date: \_\_\_\_\_ Are you taking birth control pills? YES NO

**See Reverse Side**

