NWTC DEPARTMENT OF DENTAL HYGIENE
CONFIDENTIAL CLIENT HEALTH RECORD

Office Use Only
HIPAA on File ________________
____
Appointment date ____________
____

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 Congenital Heart Defect
YES NO Heart Murmur
YES NO Heart Surgery
YES NO Artificial Heart Valve
YES NO Cardiac Stent
YES NO Pacemaker
YES NO Heart Disease
YES NO Heart Attack
YES NO Chest Pains
YES NO Rheumatic Fever
YES NO Stroke

YES NO Arthritis
YES NO Artificial Joint or Hip
YES NO Artificial Pin

YES NO Tuberculosis
YES NO Emphysema
YES NO Asthma
YES NO Sinus Trouble
YES NO Frequent Cough

YES NO Liver Disease
YES NO Hepatitis (Jaundice)
YES NO Spleen Removal
YES NO Organ Transplant
YES NO Kidney Problems

YES NO Thyroid Condition
YES NO History of Osteoporosis
YES NO Bone-loss Drugs in Cancer tx

YES NO Diabetes
YES NO Excessive Thirst
YES NO Appetite Suppressant Drugs
YES NO Rapid Weight Loss
YES NO Venereal Disease or Sexually Transmitted Disease
YES NO Herpes
YES NO HIV Positive/ AIDS

YES NO Cancer or Leukemia
YES NO Abnormal Bleeding
YES NO Blood Transfusion
YES NO Radiation Therapy When____________
YES NO Chemotherapy When____________

YES NO Autism/Asperger's
YES NO Intellectual Disability
YES NO Alzheimer's/Dementia
YES NO Psychological Disorder

YES NO Epilepsy or Seizures
YES NO Headaches

YES NO Allergies to Drug or Medications
YES NO Allergy to Penicillin
YES NO Latex
YES NO Other Allergies
YES NO Unexplained Fevers
YES NO Prolonged Sore Throat
YES NO Swollen Lymph Nodes
YES NO Night Sweats
YES NO Fainting
YES NO Tobacco Use
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

DENTAL HISTORY

Dentist's Name: ______________________ City: ______________________

Date of last visit to dentist: ______________________ Treatment Received: ______________________

Date of last cleaning: ______________________ Last dental X-rays: ______________________

How often do you brush your teeth? __________ Floss? __________ Type of X-rays: ______________________

What kind of toothbrush do you use: (soft, medium, hard) ______________________

CIRCLE any YOU have or have had:

Orthodontic Treatment (braces)
Gumboils
Periodontal (gum) Surgery
Candidiasis (thrush)
Bad Taste in Mouth
Mouth Odor
Dry Mouth
Difficult Extractions
Tooth Aches or Infections
Jaw Joint Problems
Difficulty Opening Mouth
Clench or Grind Teeth
Sensitive Teeth
Thumb or Finger Habit
Accidental injuries to teeth, mouth or jaws.
Jaw Surgery/Implant Surgery

Have you ever had an injection in your mouth? Yes ______ No ______ Any adverse reaction? ______________________

To my knowledge all of the information on this history form is correct. I understand that because Northeast Wisconsin Technical College provides only preventive services, I must make an appointment with a dentist for a thorough examination and diagnosis. I release Northeast Wisconsin Technical College from liability due to any personal injuries incurred as a result of dental hygiene services performed by employees and/or students. I understand by signing this I am giving consent to dental hygiene treatment.

Signature ______________________ Date ______________________
(patient, parent, or guardian)

In case of emergency, please contact: ______________________ Phone # ______________________
Relationship: ______________________

MEDICAL UPDATES: To be filled out by student.

DATE	UPDATES	B.P.	PATIENT'S SIGNATURE	REVIEWED BY STD.	REVIEWED BY INST.
	RR: ______ ______ BPM: ______				