MIDLANDS TECHNICAL COLLEGE

Revised 12/16/13

REGISTRATION AND HEALTH HISTORY

PERSONAL INFORMATION

(CLINICIAN USE ONLY)
MEDICAL ALERT:
No_____ Yes_____

Have you ever been a patient at MTC Dental Clinic? No____ Yes___
What is the reason for this visit? _____

Name_____ Birthdate____/____/____ Today's date ____/____/____

Home Address_____ Phone_____

City_____ State_____ Zip_____

Occupation_____ Place of Employment_____ Bus. Phone_____

Education (Check One) p Elementary p High School p College p Masters or Doctorate

Email Adress _____

Sex_____ Height_____ Weight _____ Marital Status _____

Race (Check One) p White p Black p Asian p Native American p Other_____

Emergency Contact _____ Phone_____ Alt Phone_____

Do You Have A Physician? No_____ Yes_____ Treated For_____

Name_____ Address_____ Phone #_____

City_____ State_____ Zip Code_____ Last Physical (Year)_____

Dentist_____ City_____ Phone_____ Last Seen (Year) _____

MEDICAL INFORMATION

DO YOU HAVE ANY TROUBLE

Y	N	
		A. Hearing? _____
		B. Seeing? _____
		C. Moving? _____
		D. Speaking? _____

See Attached Patient RX List

Which medications are you allergic to?
_____
What type of allergic reaction?
_____

Y	N	
		1. Are you allergic to any medications or latex? If YES, give details here:
		2. Are you taking any: Prescriptions _____ Herbs _____ Over-the-Counter _____
		3. Have you ever been seriously ill in the last five years? If YES, give details below: _____
		4. Have you ever been hospitalized or had a serious illness? If YES, give details below: _____
		5. Do you need antibiotic coverage for dental treatment?_____
		6. Persistent cough? _____
		7. Resided or worked with anyone who has had TB? _____
		8. (Women Only) Are you pregnant? _____
		9. (Women Only) Are you nursing? _____
		10. (Women Only) Are you taking birth control pills, patch, hormonal replacements, etc.? _____
		11. (Women Only) Are you in or have you been through menopause? _____

DO YOU HAVE OR HAVE YOU HAD?

Y	N		Y	N	
		12. AIDS / HIV Positive _____			22. Chemotherapy _____
		13. Allergies_____			23. Chest Pains (Angina) _____
		14. Anemia _____			24. Contact Lenses _____
		15. Arthritis / Rheumatism _____			25. Cortisone / Steroids _____
		16. Asthma / Hay Fever _____			26. Diabetes (Type I or Type II) _____
		17. Autoimmune Disease _____			27. Drug Addiction _____
		18. Bleeding Problems _____			28. Drug Reaction _____
		19. Blood Disease (Anemia) _____			29. Epilepsy (Seizures) _____
		20. Blood Transfusion _____			30. Fainting (Frequent) _____
		21. Cancer or Tumor _____			31. Other _____

If you answered YES to any, please explain:_____

DO YOU HAVE OR HAVE YOU HAD? Please Circle Appropriate Answer

Y	N		Y	N	
		32. Headaches (Frequent) _____			44. Radiation For Head / Neck Cancer _____
		33. Head Injury _____			45. Rheumatic Fever / Rheumatic Heart Disease ____
		34. Heart Trouble or Murmur _____			46. Shortness of Breath _____
		35. Heart Attack _____			47. Sinus Trouble _____
		36. Hepatitis (Jaundice) _____			48. Stomach / Intestinal Disease (Ulcers) _____
		37. High / Low Blood Pressure _____			49. Stroke _____
		38. Hives or Skin Rash _____			50. Swelling of Hands or Feet _____
		39. Kidney Disease _____			51. Thyroid Disease _____
		40. Liver Disease _____			52. Tuberculosis / Lung Disease _____
		41. Heart Valve / Pacemaker / Joint Replacement			53. Venereal Disease/ Sexual Transmitted Disease(STD)
		42. Osteoporosis _____			54. Do you have any OTHER medical condition
		43. Psychological Problems (List Below) _____			not listed? _____

HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS IN THE PAST TWO YEARS:

Y	N		Y	N	
		55. Antibiotics (Penicillin, etc.) _____			63. Insulin (Diabetes Medication) _____
		56. Anticoagulants (Blood Thinners) _____			64. High Blood Pressure Medication _____
		57. Antihistamines (Benadryl, etc.) _____			65. Nitroglycerin _____
		58. Aspirin (Advil, Nuprin, etc.)_____			66. Sulfa Drugs _____
		59. Cortisone (Steroids) _____How long?_____			67. Tranquilizers _____
		60. Digitalis (Heart Medication) _____			68. INH, Rifampin _____
		61. Bisphosphonates _____			69. Drink alcohol _____
		62. Controlled Substances _____			70. Other_____

ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO:

Y	N		Y	N	
		71. Antibiotics (Penicillin, etc.) _____			75. Local Anesthetics _____
		72. Barbiturates (Sedatives) _____			76. Narcotics _____
		73. Gluten Sensitivity _____			77. Sulfa Drugs _____
		74. Iodine _____			78. Are you allergic to Latex? _____

DENTAL INFORMATION

DO YOU:

Y	N	
		79. Have any dental pain or problems now? _____
		80. Fear the dentist or dental treatment? _____
		81. Grind or frequently clench your teeth? _____
		82. Have pain opening / closing your teeth? _____
		83. Have an unpleasant taste in your mouth? _____
		84. Have dry mouth? _____
		85. Brush your teeth less than twice a day? _____
		86. Floss your teeth less than once a day? _____
		87. Have gums that bleed when brushing or flossing?
		88. Have teeth sensitive to hot, cold, pressure or sweets? _____

HAVE YOU:

Y	N	
		89. Had problems with dental anesthesia (Xylocaine)?
		90. Had prolonged bleeding after an extraction? _____
		91. Noticed any shifting of your teeth? _____
		92. Worn Braces? _____
		93. Have gum (pyorrhea, periodontal) diseases? _____
		94. Ever had periodontal (gum) surgery? _____
		95. Date of most recent dental cleaning _____ / _____
		96. Wear dentures or a partial? _____
		97. Have any other dental condition? _____
		98. Been dissatisfied with the condition or appearance of your teeth? _____

Signature_____ Date_____
Patient or Guardian

_____ ___/___/___ _____ ___/___/___
Student Number Date Instructor Date

NOTES	DATE	REMARKS