**DELAWARE TECHNICAL AND COMMUNITY COLLEGE**
**DENTAL HEALTH CENTER**

# MEDICAL HISTORY

Name________________________________________________ Social Security #______-_______-_______
(Last) (First) (Middle Initial)
Address______________________________________________ Birthdate____________________________
(Street)
_____________________________________________________ Home Phone__________________________
(City) (State) (Zip)
Occupation___________________________________________ Business Phone_______________________

Physician's Name______________________________________ Telephone___________________________

Dentist's Name_________________________ Telephone__________ Dental Insurance Co.___________________

In case of emergency, contact___________________________________Relationship__________ Phone__________

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**PLEASE ANSWER ALL QUESTIONS (ALL RECORDS ARE CONFIDENTIAL)**

What was the date of your last physical?______________
Month/Year

Are you presently under the care of a Physician? _____

| Yes | No | | |
|---|---|---|---|
| ___ | ___ | 1. | Surgical prosthesis/Joint replacement |
| ___ | ___ | 2. | Organ transplant |
| ___ | ___ | 3. | Surgical shunt |
| ___ | ___ | 4. | Cardiovascular/Heart disease |
| ___ | ___ | 5. | Heart surgery/Valve replacement/Pacemaker |
| ___ | ___ | 6. | Rheumatic fever/Heart disease |
| ___ | ___ | 7. | Heart murmur |
| ___ | ___ | 8. | High blood pressure/Hypertension |
| ___ | ___ | 9. | Stroke |
| ___ | ___ | 10. | Blood clots |
| ___ | ___ | 11. | Endocrine/Hormonal disorders |
| ___ | ___ | 12. | Diabetes/Insulin pump |
| ___ | ___ | 13. | Thyroid condition |
| ___ | ___ | 14. | Lung disorders |
| ___ | ___ | 15. | Tuberculosis |
| ___ | ___ | 16. | Emphysema |
| ___ | ___ | 17. | Asthma |
| ___ | ___ | 18. | Sinus problems |
| ___ | ___ | 19. | Arthritis/Rheumatism |
| ___ | ___ | 20. | Immunological diseases (e.g. Lupus) |
| ___ | ___ | 21. | HIV infections/AIDS |
| ___ | ___ | 22. | Mononucleosis |
| ___ | ___ | 23. | Venereal disease(e.g. Gonorrhea, Syphilis) |
| ___ | ___ | 24. | Herpes simplex (cold sores/fever blisters) |
| ___ | ___ | 25. | Gastrointestinal disorders |
| ___ | ___ | 26. | Ulcers |

| Yes | No | | |
|---|---|---|---|
| ___ | ___ | 27. | Liver Disease/Cirrhosis |
| ___ | ___ | 28. | Hepatitis |
| ___ | ___ | 29. | Kidney disorders/Infections/Dialysis |
| ___ | ___ | 30. | Splenectomy |
| ___ | ___ | 31. | Skin disorders |
| ___ | ___ | 32. | Hemophilia (bleeding disease) |
| ___ | ___ | 33. | Anemia (thin blood) |
| ___ | ___ | 34. | Sickle cell anemia/Trait |
| ___ | ___ | 35. | Leukemia |
| ___ | ___ | 36. | Cancer |
| ___ | ___ | 37. | Radiation therapy/Chemotherapy |
| ___ | ___ | 38. | Epilepsy |
| ___ | ___ | 39. | Seizures/Convulsions |
| ___ | ___ | 40. | Mental disability |
| ___ | ___ | 41. | Cerebral palsy |
| ___ | ___ | 42. | Muscular dystrophy |
| ___ | ___ | 43. | Multiple sclerosis |
| ___ | ___ | 44. | Spina bifida |
| ___ | ___ | 45. | Alzheimer's disease/Dementia |
| ___ | ___ | 46. | Hard of hearing |
| ___ | ___ | 47. | Visual impairment |
| ___ | ___ | 48. | Back/Spinal injuries |
| ___ | ___ | 49. | Eating disorders |
| ___ | ___ | 50. | Mental health disorders (e.g. anxiety/depression) |
| ___ | ___ | 51. | Drug and/or Alcohol use |

(over)

**Have you experienced any of the following?**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ___ | ___ | 52. Leg cramps | ___ | ___ | 65. Blood transfusion(s) |
| ___ | ___ | 53. Chest pains | ___ | ___ | 66. Denied to give blood |
| ___ | ___ | 54. Shortness of breath | ___ | ___ | 67. Ingest more than 2 alcoholic beverages per day? |
| ___ | ___ | 55. Cardiovascular/Heart disease | | | |
| ___ | ___ | 56. Need for extra pillows while sleeping? | ___ | ___ | 68. Smoke and/or chew tobacco? |
| ___ | ___ | 57. Weight change | ___ | ___ | 69. Tattoo |
| ___ | ___ | 58. Frequent headaches | ___ | ___ | 70. Body piercing |
| ___ | ___ | 59. Fainting spells | ___ | ___ | 71. Do you have any reason to believe that you are at increased risk of contracting infectious or sexually transmitted diseases? |
| ___ | ___ | 60. Burning pain during urination | | | |
| ___ | ___ | 61. Coughing blood | | | |
| ___ | ___ | 62. Skin rashes or Hives | ___ | ___ | 72. Ever taken **Fen-phen**? |
| ___ | ___ | 63. Frequent vomiting and/or Diarrhea | ___ | ___ | 73. Women:Is it possible you are pregnant? |
| ___ | ___ | 64. Prolonged bleeding after injury/treatment | | | |

74. Have you been hospitalized for surgery and/or any serious illness? **Yes** ____ **No** ____

75. In reference to questions 1-74, please explain all “**yes**” answers.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

76. Are you allergic or have you reacted adversely to the following* (*itching, rashes, swelling, or difficulty breathing)

| | **Yes** | **No** | **Never Taken** | | **Yes** | **No** | **Never Taken** |
|---|---|---|---|---|---|---|---|
| Local Anesthetics | ___ | ___ | ___________ | Iodine | ___ | ___ | ___________ |
| Penicillin or other Antibiotics | ___ | ___ | ___________ | Codeine or other Narcotics | ___ | ___ | ___________ |
| Sulfa drugs | ___ | ___ | ___________ | Latex | ___ | ___ | |
| Aspirin | ___ | ___ | ___________ | Other | ___ | ___ | ___________ |

**If yes,** please explain ______________________________________________________

77. Are you taking any medications, prescriptions and/or over the counter drugs, including but not limited to Aspirin and herbal medications? **Yes**____ **No**____
**If “yes”**, please list all of these medications ________________________________________

______________________________________________________________________

______________________________________________________________________

78. Is there anything in your Medical History not covered on this form? ______________________

______________________________________________________________________

79. I verify this information is correct to the best of my knowledge:

| **Date:** | **Patient’s or Guardian’s Signature:** |
|---|---|
| ___________ | ______________________________ |
| ___________ | ______________________________ |
| ___________ | ______________________________ |
| ___________ | ______________________________ |