ID#_____

NCC Dental Clinic Medical History

Patient Initials: _____

NOTE: You will sign this form electronically in the clinic.

GENERAL HEALTH QUESTIONS: mark with an X after condition(s)							
Under a physician's care		Taking prescribed medications		Bisphosphanate drugs for osteoporosis or cancer		Controlled substance recreational drugs	
Hospitalized or had a major operation		Over the counter medications		Antibiotic premedication prior to dental treatment		Tobacco cigarettes chew or e-cig	
Serious head or neck injury		Herbal supplements		Do not write in this box.			
If yes, explain:							
ALLERGIES: are you allergic to any of the following?							
Aspirin		Codeine		Penicillin		Local anesthetics	
Sulfa drugs		Latex		Metal		Acrylic	
Food Allergies		Colophony/Resin		Red Dye		Other	
If yes, please explain:							
WOMEN are you…							
Pregnant		Are you nursing		Taking oral contraceptives		Trying to get pregnant	
CURRENT HEALTH: Do you have, or have you had, any of the following? Mark with an X after condition(s)							
Alzheimer's Disease		Anaphylaxis		Drug addiction		Renal dialysis	
Rheumatic fever		Angina		Emphysema		High cholesterol	
Scarlet fever		Hives or rash		Excessive thirst		Hypoglycemia	
Sickle cell disease		Irregular heartbeat		Sinus trouble		Blood disease	
Frequent cough		Spina bifida		Blood transfusion		Frequent diarrhea	
Leukemia		Liver disease		Bruise easily		Swelling of limbs	
Glaucoma		Thyroid disease		Chemotherapy		Hay fever	
Tonsillitis		Osteoporosis		Heart murmur		Pain in jaw joints	
Heart pacemaker		Ulcers		Hearing impaired		Epilepsy / seizures	
Arthritis		Hepatitis a, b or c		Bleeding disorder		Heart condition	
Joint replacement		Jaundice		Herpes		Gout	
Stroke		ADHD add autism		Cancer		Anemia	
Shingles		Tumors / growths		Diabetes type 1 / 2		High Blood Pressure	
Low blood pressure		Frequent headaches		Stomach / Intestinal Disease		Heart Attack / Failure	
Mitral valve prolapsed		Parathyroid disease		Cold Sores / Fever Blisters		Congenital Heart Disorder	
Sexual transmitted disease		Asthma/lung/ breathing disorder		Upper Respiratory Infection (active)		Mental Health Concerns	
Post traumatic Stress Disorder		Autoimmune condition		Kidney/Renal Disease		Neurological Disorder	
Heart surgery (including stents)		Tuberculosis (active / currently)		Cardiac/Organ Transplant		Fainting Spells / Dizziness	
Radiation treatments		Artificial/Damaged Heart Valve(s)		Immune Suppression HIV / AIDS		Cortisone Medication	
Recent weight loss		Recent eye / ear surgery		Impaired Vison		Osteonecrosis of the Jaw	
Eating Disorder		Acid Reflux		Do not write in this box			
If yes to any of the above, explain:							
Ever had serious illness not listed above? __ Yes __ No. If yes, explain:							
DENTAL CONCERNS: Do you have any of the following? Mark with an X after condition(s)							
Periodontal Treatment		Oral Surgery		Sensitive to Hot/Cold		Orthodontic Treatment	
Serious Injury to Mouth		Serious Injury to Head		Dry Mouth		Bleeding Upon Brushing	
Bite Plate or Guard		Wear Removable Prosthesis		Teeth Sensitive to Biting / Chewing			
If yes, explain:							

Disclaimer: Dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

To the best of your knowledge this form has been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Allow 1 ½ hours for radiology and 3 ½ hours for cleaning. More than one appointment may be necessary. **OVER**

Patients please complete the following information:

Doctor's Name: _____ Practice Name: _____
Phone: _____ E-mail address: _____
Location Address: _____

Dentist Name: _____ Practice Name: _____
Phone: _____ E-mail address: _____
Location Address: _____

Emergency Contact: _____ Relationship: _____
Phone #_____

FOR CLINIC ONLY

National Heart, Lung and Blood Institute
Published in Journal of American Medical Association

SEE YOUR DOCTOR REGULARLY Only he/she can help control blood pressure and advice on weight, exercise and the diet for you.

ON THIS DATE: _____YOUR BLOOD PRESSUE IS: _____/_____

_____This is NORMAL. **_____ THIS IS ELEVATED**

PLEASE SEE A DOCTOR.

Classification	Systolic		Diastolic
Normal	< 120	and	< 80
Elevated	120-129	and	< 80
High - Stage 1 Hypertension	130-139	or	80-89
High - Stage 2 Hypertension	140 and above	or	90 and above

Source: The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure.