Your Health. Your College.

Madison College Medical Dental History

1705 Hoffman Street
Madison, WI 53704
608-258-2400

Date: _____

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female ◯ Other **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **Email Address:** _____

Phone: _____ (Mobile) _____ (Work) _____ (Ext)

Address: _____ (Address 1)

_____ (City) _____ (State) _____ (Zip Code)

Emergency Contact Name/Phone #:

Are you now or have you ever been under a physician's care for any of the following conditions? ◯ Yes ◯ No

If yes, please indicate which condition(s) from the list below and include year of diagnosis.

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Cancer
- ☐ Cardiovascular
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ COPD/Emphysema
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ GERD/Digestive Issues
- ☐ Glaucoma
- ☐ Growths/Tumors
- ☐ Head Injuries
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Immunocompromised
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Health Disorder
- ☐ Mononucleosis
- ☐ Nervous Disorder
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Problems
- ☐ STDs
- ☐ Stroke
- ☐ Swelling of Feet
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vertigo, Tinnitus, or Ear Pain
- ☐ Other

Year of diagnosis.

Any other conditions? ◯ Yes ◯ No

If yes, please explain and include the year of diagnosis.

Please list your current primary Physician's/Specialist's names locations & phone numbers:

Have you ever been hospitalized, had an operation or a serious illness? ◯ Yes ◯ No

If yes, please explain and include the year of diagnosis:

Do you now or have you ever required pre-medication for dental treatment? ◯ Yes ◯ No

If yes, please explain:

Are you allergic to any of the following? Check all that apply

☐ Acrylic	☐ Iodine	☐ Metals	☐ Sulfites	☐ Tree Nuts
☐ Aspirin	☐ Latex	☐ Penicillin Drugs	☐ Tetracycline Drugs	☐ Other
☐ Codeine or other narcotics	☐ Local Anesthetic	☐ Red Dye		

If yes, please describe the reaction(s):

Do you use any of the following?

☐ Alcohol	☐ Hookah	☐ Smokeless/Chewing Tobacco
☐ Cigarettes/Cigars	☐ Marijuana	☐ Vapor Cigarettes

If yes, how often are you using these products?

Are you pregnant or nursing? ◯ Yes ◯ No

Please list any prescription medications, over-the-counter medications, vitamins/minerals or herbal remedies you are taking.

Name of Medication	Reason Taken	Adverse Reactions	Dosage

Today's Blood Pressure _____ / _____ **RAS LAS** **ASA Status** _____

Please answer the following questions regarding your dental history.

At the present time, do you have any dental concerns? ◯ Yes ◯ No
If yes, please describe:

What is your dentist's name/address/phone?

When was your last dental cleaning/exam? _____

When was the last time you had dental x-rays? _____

Have you ever been treated for periodontal/gum disease? ◯ Yes ◯ No

Have you had any serious trouble associated with any previous dental visit? ◯ Yes ◯ No
If yes, please explain.

Have you ever had local anesthetic? ◯ Yes ◯ No

If yes, did you have any reactions or symptoms from local anesthetic?

Do you have or have you ever had any of the following?

☐ Canker Sore ☐ Cold Sore/Fever Blister ☐ Unhealed Mouth Sore

Please check any of the following oral habits that you have:

☐ Chewing on pens, pencils, bobby pins, other objects ☐ Grinding your teeth ☐ Nail biting
☐ Clenching your teeth ☐ Mouth breathing ☐ Thumb sucking/Pacifiers
☐ Other

Do you now or have you ever lived in an area with fluoridated water? ◯ Yes ◯ No
If so, from what ages?

Do you have dental implants? ◯ Yes ◯ No

Which dental products do you use at home?

☐ Dental Floss **How often?** _____
☐ Manual Toothbrush **How often?** _____
☐ Toothpick **How often?** _____
☐ Electric Toothbrush **How often?** _____
☐ Mouth Rinse **How often?** _____
☐ Tongue Cleaner **How often?** _____
☐ Interdental Cleaner **How often?** _____
☐ Oral Irrigator **How often?** _____
☐ Other **How often?** _____

Do you snack during the day? ◯ Yes ◯ No

If yes, how often daily? ☐ 1x ☐ 2x ☐ 3x

What snack/beverage items do you consume?

☐ Candy/Cookies
☐ Cheese
☐ Chips/Crackers
☐ Coffee/Tea with sugar
☐ Energy Drinks
☐ Fruits
☐ Gum/Mints (sugar or sugar-free)
☐ Nuts/Seeds
☐ Soda (regular or diet)
☐ Sports Drinks
☐ Vegetables
☐ Yogurt
☐ Other

☐ * **By checking this box, I acknowledge that the information I provided is accurate to the best of my knowledge and I will inform my clinician if any changes occur.**

Signature of Patient/Guardian ______________________ **Date** __________

Reviewed by Student ______________ Instructor ______________ Dentist ______________

Date __________ **Today's BP** __________

Health Changes ______________________

CURRENT MEDICATIONS

1. ______________
2. ______________
3. ______________
4. ______________

Patient's Signature ______________ **Student Initials** ________ **Faculty Initials** ________

Date __________ **Today's BP** __________

Health Changes ______________________

CURRENT MEDICATIONS

1. ______________
2. ______________
3. ______________
4. ______________

Patient's Signature ______________ **Student Initials** ________ **Faculty Initials** ________

Date __________ **Today's BP** __________

Health Changes ______________________

CURRENT MEDICATIONS

1. ______________
2. ______________
3. ______________
4. ______________

Patient's Signature ______________ **Student Initials** ________ **Faculty Initials** ________

Medical and Dental History Update