Medical Alert Condition:	Allergy to:	**Premedication Needed:** ☐ Yes ☐ No	**BP:** ____/____ **Pulse:** ____ bpm	E-Chart Number:

NEW YORK CITY COLLEGE OF TECHNOLOGY – HEALTH HISTORY FORM

Name: Pie (LAST) Apple (FIRST) ____ (MIDDLE INITIAL) Phone: ( ) Email: apple@aol.com

Address: apple Blossom Str. City: Big apple State: NY Zip Code: 12345

Occupation: retired Height: 4.8 Weight: 145 Date of Birth: 08/16/52 **Gender:** M☐ F☑ X☐

Emergency Contact: Pie Pecan Relationship son Phone: 212-122-121

If you are completing this form for another person, what is your relationship to that person? ____ NAME ____ RELATIONSHIP

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

MEDICAL INFORMATION

	Yes	No
Are you in good health?	☐	☒
Has there been any change in your health within past year?	☒	☐
Do you have a Primary Care Provider/specialist?	☒	☐
Are you currently under the care of a physician?	☒	☐

If yes, what is/are the condition(s) being treated? Breast cancer

Date of last physical examination/medical check-up: 6/2024

Primary Care Provider/Specialist/Clinic: Dr. Stillman

ADDRESS ____ CITY/STATE ____ ZIP ____

PHONE 234-567-8901

☐ Check if your last medical check-up was outside of U.S.

	Yes	No
Have you had any serious illness, operations, or been hospitalized within the past 5 years?	☒	☐

If yes, what was the problem? Lumpectomy November 2023

Are you allergic to or have you had a reaction to?

	Yes	No
Local or topical anesthetics (like "novocaine")	☐	☒
Aspirin	☐	☒
Penicillin or other antibiotics	☐	☒
Sulfa drugs	☐	☒
Codeine or other narcotics	☐	☒
Latex	☒	☐
Iodine	☐	☒
Hay fever/seasonal	☐	☒
Food (specify) ____	☐	☒
Other (specify) ____	☐	☒
Metals (specify) ____	☐	☒

To yes responses, specify type of reaction. hives

	Yes	No
Are you taking or have you recently taken any medicine(s) including non-prescription/OTC/supplements?	☐	☐

If yes, what medicine(s) are you taking?

Name / Condition / Dosage / How long

Prescribed: NONE

Non-Prescription (OTC): Tylenol

Vitamins, natural or herbal preparations and/or diet supplements: Fish oil, echinacea, vitamins

	Yes	No
Do you consume alcohol regularly?	☐	☒

If yes, how much? ____ How often? ____

	Yes	No
Do you use drugs or other substances for recreational purposes?	☐	☒

If yes, please list:

Frequency of use (daily, weekly, etc.):

	Yes	No
Do you use tobacco (smoking/vaping, snuff, chewing)?	☐	☒

If yes, for how long have you been using tobacco? ____

If yes, how interested are you in stopping?

(*circle one*): Very / Somewhat / Not interested

	Yes	No
Have you had an orthopedic total joint replacement?* (hip, knee, elbow)	☐	☒

If yes, when was this operation done?

	Yes	No
Has a physician or dentist recommended that you take antibiotics prior to your dental treatment?	☐	☒

If yes, what antibiotic and dose?

Name of physician or dentist:

Phone:

WOMEN ONLY

	Yes	No
Are you or could you be pregnant?	☐	☒
Taking birth control pills or hormonal replacement?	☐	☒

Please complete both sides

Place an "X" to indicate if you have or have not had any of the following diseases or problems

	Yes	No
Abnormal bleeding	❑	X
AIDS or HIV infection	❑	X
Anemia	❑	X
Arthritis/ Rheumatoid arthritis	❑	X
Asthma	❑	X
Blood transfusion. If yes, date: ________	❑	X
Cancer/chemotherapy/radiation treatment	X	❑
Cardiovascular disease. If yes, specify below:	X	❑

___ Angina
X High Cholesterol
___ Artificial heart valves*
___ Congenital heart defects*
___ Congestive heart failure*
___ Coronary heart disease*
___ Damaged heart valves*
___ High blood pressure
___ Low blood pressure
___ Mitral valve prolapse
___ Pacemaker

	Yes	No
Chest pain upon exertion	❑	X
Chronic pain	❑	X
Disease, drug or radiation-induced immunosuppression	❑	X
Diabetes, If yes, specify below:	❑	X

___ Type I (Insulin dependent)
___ Type II **Most Recent HbA1c Value**: ________

	Yes	No
Eating disorder. If yes, specify: ________	❑	X
Epilepsy *	❑	X
Fainting spells or seizures	❑	X
Gastrointestinal disease	❑	X
G.E. Reflux/persistent heartburn	❑	X
Glaucoma	❑	X

***Require faculty DDS consultation**

	Yes	No
Hemophilia*	❑	X
Hepatitis	X	❑
Recurrent infections	❑	X
If yes, indicate type of infection ________		
Kidney problems	❑	X
Mental health disorders. If yes, specify ________	❑	X
Night sweats	❑	X
Neurological disorders. If yes, specify ________		
Osteoporosis	❑	X
Persistent swollen glands in neck	X	❑
Respiratory problems. If yes, specify below:	❑	X

____ Emphysema ____ Bronchitis, etc.

	Yes	No
Severe headaches, migraines	❑	X
Severe or rapid weight loss	❑	X
Sexually transmitted disease	❑	X
Sinus trouble	❑	X
Sleep disorder	❑	X
Systemic lupus erythematosus	❑	X
Tuberculosis*	❑	X
Thyroid problems	X	❑
Ulcers	❑	X
Excessive urination	❑	X
Do you have any disease, condition or problem not listed above that you think we should know about?	❑	X

Please explain: ________

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush?	❑	X
Do you have dry mouth?	X	❑
Have you had orthodontic treatment (braces/alignments)?	X	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	❑	X
Do you have earaches or neck pains?	X	❑
Do you have dental implants?	❑	X
Have you had any periodontal (gum) treatments?	❑	X
Do you wear removable dental appliances?	❑	X
Do you experience bad breath?	❑	X
Have you had a serious/difficult problem associated with any previous dental treatment?	❑	X

If yes, explain ________

How would you describe your current dental health? good

Date of your last dental check-up: Last year

What treatment was done at that time? filling

Date of your last oral hygiene services: 2022

Date of last dental x-rays: Last year #of images? One

Do you have any additional concerns? ________

I certify that I have read, understand and completed this medical history form. It is accurate to the best of my knowledge. I will not hold New York City College of Technology, the Dental Hygiene Department or its' students responsible for any action they take or do not take because of errors of omission that I may have made when completing this medical history form.

I have received the "**Notice of Privacy Practice/Bloodborne Pathogen Policy**" for the Dental Hygiene Department. I understand that this notice describes how medical/dental information about me may be used and disclosed and how I can get access to this information.
I consent to having a dental hygiene examination.

PATIENT or LEGAL GUARDIAN SIGNATURE **(sign in clinic)** **DATE**

Significant findings from oral interview: **ASA:**

Student (*name/signature*) Instructor (*name/signature*) Date

Medical Alert Condition:	Allergy to:	Premedication Needed: ☐ Yes ☐ No	BP: ____/____ Pulse: ____ bpm	E-Chart Number:

NEW YORK CITY COLLEGE OF TECHNOLOGY – HEALTH HISTORY FORM

Name: Caramel Latte (LAST / FIRST / MIDDLE INITIAL) Phone: (333 497-2105 Email: Caramel@gmail.com

Address: Starbucks Lane City: Coffee town State: PA Zip Code: 43012

Occupation: teacher Height: 5.7 Weight: 185 Date of Birth: 7/31/89 Gender: M☒ F☐ X☐

Emergency Contact: Iced tea Relationship wife Phone: ( )

If you are completing this form for another person, what is your relationship to that person? ____ NAME ____ RELATIONSHIP

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

MEDICAL INFORMATION

	Yes	No
Are you in good health?	☒	☐
Has there been any change in your health within past year?	☐	☒
Do you have a Primary Care Provider/specialist?	☐	☒
Are you currently under the care of a physician?	☐	☒

If yes, what is/are the condition(s) being treated?

Date of last physical examination/medical check-up: 5 years ago

Primary Care Provider/Specialist/Clinic:

ADDRESS CITY/STATE ZIP

PHONE

☐ Check if your last medical check-up was outside of U.S.

	Yes	No
Have you had any serious illness, operations, or been hospitalized within the past 5 years?	☐	☒

If yes, what was the problem?

Are you allergic to or have you had a reaction to?	Yes	No
Local or topical anesthetics (like "novocaine")	☐	☒
Aspirin	☐	☒
Penicillin or other antibiotics	☒	☐
Sulfa drugs	☐	☒
Codeine or other narcotics	☐	☒
Latex	☐	☒
Iodine	☐	☒
Hay fever/seasonal	☐	☒
Food (specify)	☐	☒
Other (specify)	☐	☒
Metals (specify)	☐	☒

To yes responses, specify type of reaction.
Can't Breathe

	Yes	No
Are you taking or have you recently taken any medicine(s) including non-prescription/OTC/supplements?	☐	☐

If yes, what medicine(s) are you taking?

	Name	Condition	Dosage	How long
Prescribed:				

Non-Prescription (OTC): Vitamin D

Vitamins, natural or herbal preparations and/or diet supplements: Fish Oil

	Yes	No
Do you consume alcohol regularly?	✓	☐

If yes, how much? 2 beers How often? Weekends

	Yes	No
Do you use drugs or other substances for recreational purposes?	✓	☐

If yes, please list:

Frequency of use (daily, weekly, etc.):

	Yes	No
Do you use tobacco (smoking/(vaping), snuff, chewing)?	✓	☐

If yes, for how long have you been using tobacco?
If yes, how interested are you in stopping?
(*circle one*): Very / Somewhat / Not interested

	Yes	No
Have you had an orthopedic total joint replacement?* (hip, knee, elbow)	☐	☒

If yes, when was this operation done?

	Yes	No
Has a physician or dentist recommended that you take antibiotics prior to your dental treatment?	☐	☒

If yes, what antibiotic and dose?

Name of physician or dentist:

Phone:

WOMEN ONLY

Are you or could you be pregnant?	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐

Please complete both sides

Place an "X" to indicate if you have or have not had any of the following diseases or problems

	Yes	No
Abnormal bleeding	[ ]	[X]
AIDS or HIV infection	[ ]	[X]
Anemia	[ ]	[X]
Arthritis/ Rheumatoid arthritis	[ ]	[X]
Asthma	[ ]	[X]
Blood transfusion. If yes, date: ____________	[ ]	[X]
Cancer/chemotherapy/radiation treatment	[ ]	[X]
Cardiovascular disease. If yes, specify below:	[ ]	[X]

____ Angina
____ High Cholesterol ____ High blood pressure
____ Artificial heart valves* ____ Low blood pressure
____ Congenital heart defects* ____ Mitral valve prolapse
____ Congestive heart failure* ____ Pacemaker
____ Coronary heart disease*
____ Damaged heart valves*

	Yes	No
Chest pain upon exertion	[ ]	[X]
Chronic pain	[ ]	[X]
Disease, drug or radiation-induced immunosuppression	[ ]	[X]
Diabetes, If yes, specify below:	[ ]	[X]

____ Type I (Insulin dependent)
____ Type II **Most Recent HbA1c Value**: __________

	Yes	No
Eating disorder. If yes, specify: ____________	[ ]	[ ]
Epilepsy *	[X]	[ ]
Fainting spells or seizures	[ ]	[X]
Gastrointestinal disease	[ ]	[X]
G.E. Reflux/persistent heartburn	[ ]	[X]
Glaucoma	[ ]	[X]

***Require faculty DDS consultation**

	Yes	No
Hemophilia*	[ ]	[ ]
Hepatitis	[ ]	[ ]
Recurrent infections	[ ]	[ ]
If yes, indicate type of infection ____________		
Kidney problems	[ ]	[ ]
Mental health disorders. If yes, specify ____________	[ ]	[ ]
Night sweats	[ ]	[ ]
Neurological disorders. If yes, specify ____________		
Osteoporosis	[ ]	[ ]
Persistent swollen glands in neck	[ ]	[ ]
Respiratory problems. If yes, specify below:	[ ]	[ ]

____ Emphysema ____ Bronchitis, etc.

	Yes	No
Severe headaches, migraines	[ ]	[ ]
Severe or rapid weight loss	[ ]	[ ]
Sexually transmitted disease	[ ]	[ ]
Sinus trouble	[ ]	[ ]
Sleep disorder	[ ]	[ ]
Systemic lupus erythematosus	[ ]	[ ]
Tuberculosis*	[ ]	[ ]
Thyroid problems	[ ]	[ ]
Ulcers	[ ]	[ ]
Excessive urination	[ ]	[ ]
Do you have any disease, condition or problem not listed above that you think we should know about?	[ ]	[ ]

Please explain: ____________

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush?	[X]	[ ]
Do you have dry mouth?	[ ]	[X]
Have you had orthodontic treatment (braces/alignments)?	[ ]	[X]
Are your teeth sensitive to cold, hot, sweets or pressure?	[X]	[ ]
Do you have earaches or neck pains?	[ ]	[X]
Do you have dental implants?	[ ]	[X]
Have you had any periodontal (gum) treatments?	[ ]	[X]
Do you wear removable dental appliances?	[X]	[ ]
Do you experience bad breath?	[X]	[ ]
Have you had a serious/difficult problem associated with any previous dental treatment?	[ ]	[X]

If yes, explain ____________

How would you describe your current dental health? good enough

Date of your last dental check-up: more than 5 years ago

What treatment was done at that time? pulled tooth

Date of your last oral hygiene services: don't remember

Date of last dental x-rays: ____ #of images? ____

Do you have any additional concerns? ____________

I certify that I have read, understand and completed this medical history form. It is accurate to the best of my knowledge. I will not hold New York City College of Technology, the Dental Hygiene Department or its' students responsible for any action they take or do not take because of errors of omission that I may have made when completing this medical history form.

I have received the "**Notice of Privacy Practice/Bloodborne Pathogen Policy**" for the Dental Hygiene Department. I understand that this notice describes how medical/dental information about me may be used and disclosed and how I can get access to this information.
I consent to having a dental hygiene examination.

PATIENT or LEGAL GUARDIAN SIGNATURE **(sign in clinic)** **DATE**

Significant findings from oral interview: **ASA:**

Student (*name/signature*) Instructor (*name/signature*) Date

Medical Alert Condition:	Allergy to:	Premedication Needed: ☐ Yes ☐ No	BP: ____/____ Pulse: ____ bpm	E-Chart Number:

NEW YORK CITY COLLEGE OF TECHNOLOGY – HEALTH HISTORY FORM

Name: Vanilla (LAST) Bean (FIRST) ____ (MIDDLE INITIAL) Phone: (123) 456-7890 Email: V.Bean@g.mail

Address: Cherry Dr. City: Bubble tea State: KT Zip Code: 000000

Occupation: Vanilla cookie Height: 6.1 Weight: 220 Date of Birth: 9/1/78 Gender: M☒ F☐ X☐

Emergency Contact: Vanilla Cookie Relationship mother Phone: ( )

If you are completing this form for another person, what is your relationship to that person? ____ NAME ____ RELATIONSHIP

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

MEDICAL INFORMATION

	Yes	No
Are you in good health?	☐	☐
Has there been any change in your health within past year?	☐	☐
Do you have a Primary Care Provider/specialist?	☐	☐
Are you currently under the care of a physician?	☐	☐

If yes, what is/are the condition(s) being treated?

Date of last physical examination/medical check-up: 3/2/24

Primary Care Provider/Specialist/Clinic: Dr. Bass

45 Degree Street (ADDRESS) NY (CITY/STATE) 11210 (ZIP)

111-23-4567 (PHONE)

☐ Check if your last medical check-up was outside of U.S.

	Yes	No
Have you had any serious illness, operations, or been hospitalized within the past 5 years?	☒	☐

If yes, what was the problem? I had a hip replacement twice (2018) and (2024)

Are you allergic to or have you had a reaction to?

	Yes	No
Local or topical anesthetics (like "novocaine")	☐	☒
Aspirin	☐	☒
Penicillin or other antibiotics	☐	☒
Sulfa drugs	☐	☒
Codeine or other narcotics	☐	☒
Latex	☒	☐
Iodine	☐	☒
Hay fever/seasonal	☐	☒
Food (specify) ____	☐	☒
Other (specify) ____	☐	☒
Metals (specify) ____	☐	☒

To yes responses, specify type of reaction.

	Yes	No
Are you taking or have you recently taken any medicine(s) including non-prescription/OTC/supplements?	☐	☐

If yes, what medicine(s) are you taking?

	Name	Condition	Dosage	How long
Prescribed:	Celebrex for pain			

Non-Prescription (OTC):

Vitamins, natural or herbal preparations and/or diet supplements:

	Yes	No
Do you consume alcohol regularly?	☐	☒

If yes, how much? ____ How often? ____

	Yes	No
Do you use drugs or other substances for recreational purposes?	☐	☒

If yes, please list:

Frequency of use (daily, weekly, etc.):

	Yes	No
Do you use tobacco (smoking/vaping, snuff, chewing)?	☒	☐

If yes, for how long have you been using tobacco? ____

If yes, how interested are you in stopping? (*circle one*): Very / Somewhat / Not interested

	Yes	No
Have you had an orthopedic total joint replacement?* (hip, knee, elbow)	☒	☐

If yes, when was this operation done? 2018, 2024

	Yes	No
Has a physician or dentist recommended that you take antibiotics prior to your dental treatment?	☒	☐

If yes, what antibiotic and dose? I don't know

Name of physician or dentist:

Phone:

WOMEN ONLY

	Yes	No
Are you or could you be pregnant?	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐

Please complete both sides

Place an "X" to indicate if you have or have not had any of the following diseases or problems

	Yes	No
Abnormal bleeding	X	
AIDS or HIV infection		X
Anemia		X
Arthritis/ Rheumatoid arthritis	X	
Asthma		X
Blood transfusion. If yes, date: ____________		X
Cancer/chemotherapy/radiation treatment		X
Cardiovascular disease. If yes, specify below:		X

____ Angina
____ High Cholesterol ____ High blood pressure
____ Artificial heart valves* ____ Low blood pressure
____ Congenital heart defects* ____ Mitral valve prolapse
____ Congestive heart failure* ____ Pacemaker
____ Coronary heart disease*
____ Damaged heart valves*

	Yes	No
Chest pain upon exertion		X
Chronic pain		X
Disease, drug or radiation-induced immunosuppression		X
Diabetes, If yes, specify below:		X

____ Type I (Insulin dependent)
____ Type II **Most Recent HbA1c Value**: __________

	Yes	No
Eating disorder. If yes, specify: ____________		X
Epilepsy *		X
Fainting spells or seizures		X
Gastrointestinal disease		X
G.E. Reflux/persistent heartburn		X
Glaucoma		X

***Require faculty DDS consultation**

	Yes	No
Hemophilia*		X
Hepatitis		X
Recurrent infections		X
If yes, indicate type of infection ____________		
Kidney problems		X
Mental health disorders. If yes, specify ____________		X
Night sweats		X
Neurological disorders. If yes, specify ____________		
Osteoporosis		X
Persistent swollen glands in neck		X
Respiratory problems. If yes, specify below: ____ Emphysema ____ Bronchitis, etc.		X
Severe headaches, migraines		X
Severe or rapid weight loss		X
Sexually transmitted disease		X
Sinus trouble		X
Sleep disorder		X
Systemic lupus erythematosus		X
Tuberculosis*		X
Thyroid problems		X
Ulcers		X
Excessive urination		X
Do you have any disease, condition or problem not listed above that you think we should know about?		X

Please explain: ______________________________

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush?	✓	
Do you have dry mouth?		✓
Have you had orthodontic treatment (braces/alignments)?	✓	
Are your teeth sensitive to cold, hot, sweets or pressure?	✓	
Do you have earaches or neck pains?		✓
Do you have dental implants?		✓
Have you had any periodontal (gum) treatments?		✓
Do you wear removable dental appliances?		✓
Do you experience bad breath?		✓
Have you had a serious/difficult problem associated with any previous dental treatment?		✓

If yes, explain: Sensitive to cold

How would you describe your current dental health? Good

Date of your last dental check-up: Dec. 2022

What treatment was done at that time? ____________

Date of your last oral hygiene services: Dec. 2022

Date of last dental x-rays: ____________ #of images? Don't remem[b]

Do you have any additional concerns? NO

I certify that I have read, understand and completed this medical history form. It is accurate to the best of my knowledge. I will not hold New York City College of Technology, the Dental Hygiene Department or its' students responsible for any action they take or do not take because of errors of omission that I may have made when completing this medical history form.

I have received the "**Notice of Privacy Practice/Bloodborne Pathogen Policy**" for the Dental Hygiene Department. I understand that this notice describes how medical/dental information about me may be used and disclosed and how I can get access to this information.
I consent to having a dental hygiene examination.

PATIENT or LEGAL GUARDIAN SIGNATURE **(sign in clinic)** **DATE**

Significant findings from oral interview: **ASA:**

Student (*name/signature*) Instructor (*name/signature*) Date

Medical Alert Condition:	Allergy to:	**Premedication Needed:** ☐ Yes ☐ No	**BP:** ____/____ **Pulse:** ____ **bpm**	E-Chart Number:

NEW YORK CITY COLLEGE OF TECHNOLOGY – HEALTH HISTORY FORM

Name: Rainbow Sprinkles (LAST / FIRST / MIDDLE INITIAL) Phone: 123 456-7890 Email: rainbow@yahoo.com

Address: 100 Rainbow Road City: Candy Land State: NY Zip Code: 11111

Occupation: Baker Height: 4, 11 Weight: 165 Date of Birth: 01/01/95 **Gender:** M☐ F☒ X☐

Emergency Contact: Chocolate Sprinkles Relationship Phone: ( )

If you are completing this form for another person, what is your relationship to that person? ____ NAME ____ RELATIONSHIP

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

MEDICAL INFORMATION

	Yes	No
Are you in good health?	☒	☐
Has there been any change in your health within past year?	☒	☐
Do you have a Primary Care Provider/specialist?	☒	☐
Are you currently under the care of a physician?	☐	☒

If yes, what is/are the condition(s) being treated?

Date of last physical examination/medical check-up: 1/17/24

Primary Care Provider/Specialist/Clinic: Dr. Icecream

45 degree Street (ADDRESS) NY (CITY/STATE) 10001 (ZIP)

212-123-4567 (PHONE)

☐ Check if your last medical check-up was outside of U.S.

	Yes	No
Have you had any serious illness, operations, or been hospitalized within the past 5 years?	☒	☐

If yes, what was the problem? Cataract surgery in February

Are you allergic to or have you had a reaction to?

	Yes	No
Local or topical anesthetics (like "novocaine")	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☒	☐
Sulfa drugs	☐	☐
Codeine or other narcotics	☐	☐
Latex	☐	☐
Iodine	☐	☐
Hay fever/seasonal	☐	☐
Food (specify) Strawberries	☒	☐
Other (specify)	☐	☐
Metals (specify)	☐	☐

To yes responses, specify type of reaction. Rash, itchiness

	Yes	No
Are you taking or have you recently taken any medicine(s) including non-prescription/OTC/supplements?	☐	☐

If yes, what medicine(s) are you taking?

	Name	Condition	Dosage	How long
Prescribed:	Topamax	migraines	50 mg	1 y[illegible]
	metformin	diabetes		
	Losartan	High Blood pressure	100[illegible]	

Non-Prescription (OTC): NONE

Vitamins, natural or herbal preparations and/or diet supplements: Zinc, elderberry

	Yes	No
Do you consume alcohol regularly?	☒	☐

If yes, how much? 2 glasses of wine How often? 1/week

	Yes	No
Do you use drugs or other substances for recreational purposes?	☐	☒

If yes, please list:

Frequency of use (daily, weekly, etc.):

	Yes	No
Do you use tobacco (smoking/vaping, snuff, chewing)?	☐	☒

If yes, for how long have you been using tobacco?

If yes, how interested are you in stopping?

(*circle one*): Very / Somewhat / Not interested

	Yes	No
Have you had an orthopedic total joint replacement?* (hip, knee, elbow)	☐	☒

If yes, when was this operation done?

	Yes	No
Has a physician or dentist recommended that you take antibiotics prior to your dental treatment?	☐	☒

If yes, what antibiotic and dose?

Name of physician or dentist:

Phone:

WOMEN ONLY

	Yes	No
Are you or could you be pregnant?	☐	☒
Taking birth control pills or hormonal replacement?	☒	☐

Please complete both sides

Place an "X" to indicate if you have or have not had any of the following diseases or problems

	Yes	No
Abnormal bleeding	❑	☒
AIDS or HIV infection	❑	☒
Anemia	❑	☒
Arthritis/ Rheumatoid arthritis	❑	☒
Asthma	❑	☒
Blood transfusion. If yes, date: ________	❑	☒
Cancer/chemotherapy/radiation treatment	❑	☒
Cardiovascular disease. If yes, specify below:	☒	❑

____ Angina
____ High Cholesterol
____ Artificial heart valves*
____ Congenital heart defects*
____ Congestive heart failure*
____ Coronary heart disease*
____ Damaged heart valves*
X High blood pressure
____ Low blood pressure
____ Mitral valve prolapse
____ Pacemaker

	Yes	No
Chest pain upon exertion	❑	☒
Chronic pain	❑	☒
Disease, drug or radiation-induced immunosuppression	❑	☒
Diabetes, If yes, specify below:	☒	❑

____ Type I (Insulin dependent)
____ Type II **Most Recent HbA1c Value**: ________

	Yes	No
Eating disorder. If yes, specify: ________	❑	❑
Epilepsy *	❑	❑
Fainting spells or seizures	❑	❑
Gastrointestinal disease	❑	❑
G.E. Reflux/persistent heartburn	❑	❑
Glaucoma	❑	❑

***Require faculty DDS consultation**

	Yes	No
Hemophilia*	❑	☒
Hepatitis	❑	☒
Recurrent infections	❑	☒
If yes, indicate type of infection ________		
Kidney problems	❑	☒
Mental health disorders. If yes, specify ________	❑	☒
Night sweats	❑	☒
Neurological disorders. If yes, specify ________		
Osteoporosis	❑	☒
Persistent swollen glands in neck	❑	☒
Respiratory problems. If yes, specify below:	❑	☒

____ Emphysema ____ Bronchitis, etc.

	Yes	No
Severe headaches, migraines	☒	❑
Severe or rapid weight loss	❑	☒
Sexually transmitted disease	❑	☒
Sinus trouble	❑	☒
Sleep disorder	❑	☒
Systemic lupus erythematosus	❑	☒
Tuberculosis*	❑	☒
Thyroid problems	❑	☒
Ulcers	❑	☒
Excessive urination	❑	☒
Do you have any disease, condition or problem not listed above that you think we should know about?	❑	☒

Please explain: ________

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush?	☒	❑
Do you have dry mouth?	☒	❑
Have you had orthodontic treatment (braces/alignments)?	☒	❑
Are your teeth sensitive to cold, hot, sweets or pressure?	☒	❑
Do you have earaches or neck pains?	❑	☒
Do you have dental implants?	❑	☒
Have you had any periodontal (gum) treatments?	❑	☒
Do you wear removable dental appliances?	❑	☒
Do you experience bad breath?	❑	☒
Have you had a serious/difficult problem associated with any previous dental treatment?	❑	☒

If yes, explain ________

How would you describe your current dental health? Not good

Date of your last dental check-up: 7/1/2020

What treatment was done at that time? cleaning x-rays

Date of your last oral hygiene services: 7/1/2020

Date of last dental x-rays: 7/1/20 #of images? 1

Do you have any additional concerns? ________

I certify that I have read, understand and completed this medical history form. It is accurate to the best of my knowledge. I will not hold New York City College of Technology, the Dental Hygiene Department or its' students responsible for any action they take or do not take because of errors of omission that I may have made when completing this medical history form.

I have received the "**Notice of Privacy Practice/Bloodborne Pathogen Policy**" for the Dental Hygiene Department. I understand that this notice describes how medical/dental information about me may be used and disclosed and how I can get access to this information.
I consent to having a dental hygiene examination.

PATIENT or LEGAL GUARDIAN SIGNATURE **(sign in clinic)** **DATE**

Significant findings from oral interview: **ASA:**

Student (*name/signature*) Instructor (*name/signature*) Date

Medical Alert Condition:	Allergy to:	**Premedication Needed:** ☐ Yes ☐ No	**BP:** ______/______ **Pulse:** ______ **bpm**	E-Chart Number:

NEW YORK CITY COLLEGE OF TECHNOLOGY – HEALTH HISTORY FORM

Name: Chocolate (LAST) Chip (FIRST) MIDDLE INITIAL Phone: 212 212 2212 Email: chip@gmail

Address: 300 Jay Street City: Brooklyn State: NY Zip Code: 10001

Occupation: Security Height: 6.2 Weight: 190 Date of Birth: 01/02/67 **Gender:** M☑ F☐ X☐

Emergency Contact: Cherry Cola Relationship girlfriend Phone: (123) 456 7890

If you are completing this form for another person, what is your relationship to that person? ______ NAME ______ RELATIONSHIP

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

MEDICAL INFORMATION

	Yes	No
Are you in good health?	☐	☑
Has there been any change in your health within past year?	☐	☑
Do you have a Primary Care Provider/specialist?	☑	☐
Are you currently under the care of a physician?	☑	☐

If yes, what is/are the condition(s) being treated?

Date of last physical examination/medical check-up: 06/09/24

Primary Care Provider/Specialist/Clinic: Dr. Oz

123 Hollywood Blvd. CA 90210
ADDRESS CITY/STATE ZIP

______ PHONE

☐ Check if your last medical check-up was outside of U.S.

	Yes	No
Have you had any serious illness, operations, or been hospitalized within the past 5 years?	☑	☐

If yes, what was the problem? Heart Surgery (valve replacement) in 2023

Are you allergic to or have you had a reaction to?

	Yes	No
Local or topical anesthetics (like "novocaine")	☐	☒
Aspirin	☐	☒
Penicillin or other antibiotics	☒	☐
Sulfa drugs	☐	☒
Codeine or other narcotics	☐	☒
Latex	☐	☒
Iodine	☐	☒
Hay fever/seasonal	☐	☒
Food (specify) ______	☐	☒
Other (specify) ______	☐	☒
Metals (specify) ______	☐	☒

To yes responses, specify type of reaction. Difficulty Breathing

	Yes	No
Are you taking or have you recently taken any medicine(s) including non-prescription/OTC/supplements?	☐	☐

If yes, what medicine(s) are you taking?

Name / Condition / Dosage / How long

Prescribed:
Aspirin 81 mg
Atorvastatin 5 mg
Amlodipine 10 mg for High Blood pressure

Non-Prescription (OTC):

Vitamins, natural or herbal preparations and/or diet supplements:
Vit. C

	Yes	No
Do you consume alcohol regularly?	☐	☒

If yes, how much? NO How often?

	Yes	No
Do you use drugs or other substances for recreational purposes?	☐	☒

If yes, please list:

Frequency of use (daily, weekly, etc.):

	Yes	No
Do you use tobacco (smoking/vaping, snuff, chewing)?	☒	☐

If yes, for how long have you been using tobacco? 20 years

If yes, how interested are you in stopping?
(*circle one*): Very / Somewhat / (Not interested)

	Yes	No
Have you had an orthopedic total joint replacement?* (hip, knee, elbow)	☐	☑

If yes, when was this operation done?

	Yes	No
Has a physician or dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐

If yes, what antibiotic and dose?

Name of physician or dentist:

Phone:

WOMEN ONLY

Are you or could you be pregnant?	☐	☐
Taking birth control pills or hormonal replacement?	☐	☐

Please complete both sides

Place an "X" to indicate if you have or have not had any of the following diseases or problems

	Yes	No
Abnormal bleeding	☐	☑
AIDS or HIV infection	☐	☑
Anemia	☐	☑
Arthritis/ Rheumatoid arthritis	☐	☑
Asthma	☐	☑
Blood transfusion. If yes, date: ____________	☐	☑
Cancer/chemotherapy/radiation treatment	☐	☑
Cardiovascular disease. If yes, specify below:	☑	☐

____ Angina
✓ High Cholesterol
✓ Artificial heart valves*
____ Congenital heart defects*
____ Congestive heart failure*
____ Coronary heart disease*
____ Damaged heart valves*
✓ High blood pressure
____ Low blood pressure
____ Mitral valve prolapse
____ Pacemaker

	Yes	No
Chest pain upon exertion	☐	☑
Chronic pain	☐	☑
Disease, drug or radiation-induced immunosuppression	☐	☑
Diabetes, If yes, specify below:	☐	☑

____ Type I (Insulin dependent)
____ Type II **Most Recent HbA1c Value:** __________

	Yes	No
Eating disorder. If yes, specify: ____________	☐	☑
Epilepsy *	☐	☑
Fainting spells or seizures	☐	☑
Gastrointestinal disease	☐	☑
G.E. Reflux/persistent heartburn	☐	☑
Glaucoma	☐	☑

***Require faculty DDS consultation**

	Yes	No
Hemophilia*	☐	☑
Hepatitis	☑	☐
Recurrent infections	☐	☑
If yes, indicate type of infection ____________		
Kidney problems	☐	☑
Mental health disorders. If yes, specify ____________	☐	☑
Night sweats	☐	☑
Neurological disorders. If yes, specify ____________		
Osteoporosis	☐	☑
Persistent swollen glands in neck	☐	☑
Respiratory problems. If yes, specify below:	☐	☑
____ Emphysema ____ Bronchitis, etc.		
Severe headaches, migraines	☐	☑
Severe or rapid weight loss	☐	☑
Sexually transmitted disease	☐	☑
Sinus trouble	☐	☑
Sleep disorder	☐	☑
Systemic lupus erythematosus	☐	☑
Tuberculosis*	☐	☑
Thyroid problems	☐	☑
Ulcers	☐	☑
Excessive urination	☐	☑
Do you have any disease, condition or problem not listed above that you think we should know about?	☐	☑

Please explain: ____

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush?	☑	☐
Do you have dry mouth?	☑	☐
Have you had orthodontic treatment (braces/alignments)?	☐	☑
Are your teeth sensitive to cold, hot, sweets or pressure?	☑	☐
Do you have earaches or neck pains?	☐	☑
Do you have dental implants?	☐	☑
Have you had any periodontal (gum) treatments?	☐	☑
Do you wear removable dental appliances?	☐	☑
Do you experience bad breath?	☐	☑
Have you had a serious/difficult problem associated with any previous dental treatment?	☐	☑

If yes, explain ____

How would you describe your current dental health? good

Date of your last dental check-up: Last year

What treatment was done at that time? don't remember

Date of your last oral hygiene services: Last year

Date of last dental x-rays: — #of images? —

Do you have any additional concerns? —

I certify that I have read, understand and completed this medical history form. It is accurate to the best of my knowledge. I will not hold New York City College of Technology, the Dental Hygiene Department or its' students responsible for any action they take or do not take because of errors of omission that I may have made when completing this medical history form.

I have received the "**Notice of Privacy Practice/Bloodborne Pathogen Policy**" for the Dental Hygiene Department. I understand that this notice describes how medical/dental information about me may be used and disclosed and how I can get access to this information.
I consent to having a dental hygiene examination.

PATIENT or LEGAL GUARDIAN SIGNATURE **(sign in clinic)** **DATE**

Significant findings from oral interview: **ASA:**

Student (*name/signature*) Instructor (*name/signature*) Date

Medical Alert Condition:	Allergy to:	**Premedication Needed:** ☐ Yes ☐ No	**BP:** ______/______ **Pulse:** ______ bpm	E-Chart Number:

NEW YORK CITY COLLEGE OF TECHNOLOGY – HEALTH HISTORY FORM

Name: Raspberry (LAST) Red (FIRST) MIDDLE INITIAL Phone: 718) 001-0132 Email: Raspberry@gmail.com

Address: 300 Jay Street City: Brooklyn State: NY Zip Code: 11201

Occupation: Broker Height: 5.5 Weight: 175 Date of Birth: 5/21/1972 **Gender:** M☐ F☒ X☐

Emergency Contact: Raspberry Blue Relationship Spouse Phone: 718) 0020222

If you are completing this form for another person, what is your relationship to that person? ______ NAME ______ RELATIONSHIP

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you.

MEDICAL INFORMATION

	Yes	No
Are you in good health?	☒	☐
Has there been any change in your health within past year?	☐	☒
Do you have a Primary Care Provider/specialist?	☒	☐
Are you currently under the care of a physician?	☒	☐

If yes, what is/are the condition(s) being treated? ______

Date of last physical examination/medical check-up: ______

Primary Care Provider/Specialist/Clinic: Dr. O2

123 Yellow Lane (ADDRESS) Brooklyn NY (CITY/STATE) 11200 (ZIP)

______ PHONE

☐ Check if your last medical check-up was outside of U.S.

	Yes	No
Have you had any serious illness, operations, or been hospitalized within the past 5 years?	☐	☒

If yes, what was the problem? ______

Are you allergic to or have you had a reaction to?

	Yes	No
Local or topical anesthetics (like "novocaine")	☐	☐
Aspirin	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☒	☐
Codeine or other narcotics	☐	☐
Latex	☐	☐
Iodine	☐	☐
Hay fever/seasonal	☐	☐
Food (specify) ______	☐	☐
Other (specify) ______	☐	☐
Metals (specify) ______	☐	☐

To yes responses, specify type of reaction. Hives

	Yes	No
Are you taking or have you recently taken any medicine(s) including non-prescription/OTC/supplements?	☒	☐

If yes, what medicine(s) are you taking?

	Name	Condition	Dosage	How long
Prescribed:	Albuterol Inhaler			
	Hydrocortizone cream			
Non-Prescription (OTC):				
Vitamins, natural or herbal preparations and/or diet supplements:				

	Yes	No
Do you consume alcohol regularly?	☒	☐

If yes, how much? 1 beer How often? Weekly

	Yes	No
Do you use drugs or other substances for recreational purposes?	☐	☒

If yes, please list: ______

Frequency of use (daily, weekly, etc.): ______

	Yes	No
Do you use tobacco (smoking/vaping, snuff, chewing)?	☐	☒

If yes, for how long have you been using tobacco? ______
If yes, how interested are you in stopping?
(*circle one*): Very / Somewhat / Not interested

	Yes	No
Have you had an orthopedic total joint replacement?* (hip, knee, elbow)	☐	☒

If yes, when was this operation done? ______

	Yes	No
Has a physician or dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐

If yes, what antibiotic and dose? ______

Name of physician or dentist: ______

Phone: ______

WOMEN ONLY

	Yes	No
Are you or could you be pregnant?	☐	☒
Taking birth control pills or hormonal replacement?	☒	☐

Please complete both sides

Place an "X" to indicate if you have or have not had any of the following diseases or problems

	Yes	No
Abnormal bleeding	☐	X
AIDS or HIV infection	☐	X
Anemia	☐	X
Arthritis/ Rheumatoid arthritis	☐	X
Asthma	X	☐
Blood transfusion. If yes, date: ____________	☐	X
Cancer/chemotherapy/radiation treatment	☐	X
Cardiovascular disease. If yes, specify below:	☐	X

____ Angina
____ High Cholesterol ____ High blood pressure
____ Artificial heart valves* ____ Low blood pressure
____ Congenital heart defects* ____ Mitral valve prolapse
____ Congestive heart failure* ____ Pacemaker
____ Coronary heart disease*
____ Damaged heart valves*

	Yes	No
Chest pain upon exertion	☐	X
Chronic pain	☐	X
Disease, drug or radiation-induced immunosuppression	☐	X
Diabetes, If yes, specify below:	☐	X

____ Type I (Insulin dependent)
____ Type II **Most Recent HbA1c Value**: __________

	Yes	No
Eating disorder. If yes, specify: ____________	☐	X
Epilepsy *	☐	X
Fainting spells or seizures	☐	X
Gastrointestinal disease	☐	X
G.E. Reflux/persistent heartburn	☐	X
Glaucoma	☐	X

***Require faculty DDS consultation**

	Yes	No
Hemophilia*	☐	X
Hepatitis	☐	X
Recurrent infections	☐	X
If yes, indicate type of infection ____________		
Kidney problems	☐	X
Mental health disorders. If yes, specify ____________	☐	X
Night sweats	☐	X
Neurological disorders. If yes, specify ____________		
Osteoporosis	☐	X
Persistent swollen glands in neck	☐	X
Respiratory problems. If yes, specify below:	☐	X

____ Emphysema ____ Bronchitis, etc.

	Yes	No
Severe headaches, migraines	☐	X
Severe or rapid weight loss	☐	X
Sexually transmitted disease	☐	X
Sinus trouble	☐	X
Sleep disorder	☐	X
Systemic lupus erythematosus	☐	X
Tuberculosis*	☐	X
Thyroid problems	☐	X
Ulcers	☐	X
Excessive urination	☐	X
Do you have any disease, condition or problem not listed above that you think we should know about?	X	☐

Please explain: Eczema

DENTAL INFORMATION

	Yes	No
Do your gums bleed when you brush?	X	☐
Do you have dry mouth?	X	☐
Have you had orthodontic treatment (braces/alignments)?	☐	X
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	X
Do you have earaches or neck pains?	☐	X
Do you have dental implants?	☐	X
Have you had any periodontal (gum) treatments?	☐	X
Do you wear removable dental appliances?	☐	X
Do you experience bad breath?	☐	X
Have you had a serious/difficult problem associated with any previous dental treatment?	X	☐

If yes, explain filling

How would you describe your current dental health? Good

Date of your last dental check-up: two years ago

What treatment was done at that time? filling

Date of your last oral hygiene services: two years ago

Date of last dental x-rays: Not sure #of images?

Do you have any additional concerns? NO

I certify that I have read, understand and completed this medical history form. It is accurate to the best of my knowledge. I will not hold New York City College of Technology, the Dental Hygiene Department or its' students responsible for any action they take or do not take because of errors of omission that I may have made when completing this medical history form.

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PATIENT or LEGAL GUARDIAN SIGNATURE **(sign in clinic)** **DATE**

Significant findings from oral interview: **ASA:**

Student (*name/signature*) Instructor (*name/signature*) Date