Medical Alert Allergy to: Condition:	Premedication Needed:	BP:/	E-Chart Number:	
		Pulse: bpm		
NEW YORK C	TITY COLLEGE OF TECH	INOLOGY – HEALTH HI	STORY FORM	
Name: Pre Apple	Phone: ()	Email: applea	201-10
Address: LASTapple (BLESSOU	MIDDLE INITIAL City:	apple	State: 19 Zip Code	12345
Occupation: refored	Height: 4-8 We	eight: 145 Date of Birt	h:08/16/52 Gende	er: MO PO XO
Emergency Contact: Die Deaan	Relationsh	CIOIA	Phone:	2/2/22/2
If you are completing this form for another person,	what is your relationship to the	hat person?		
For the following questions, please (X) whichever applies. Your answers are	for our records only and will be kept confid	NAME dential in accordance with applicable laws.	RELATIONS Please note that during your initial visit you	
about your responses to this questionnaire and there may be additional questic	ons concerning your health. This information MEDICAL INI	What who stay the party of the stay of the	care for you.	
		TO A TENNESS OF THE PARTY OF THE PROPERTY OF THE PARTY OF		
Are you in good health? Has there been any change in your health within past year?	Yes No '\(\)\(\)\(\)		prescription/OTC/supplements?	Yes No
Do you have a Primary Care Provider/specialist?	X . 0	If yes, what medicine(s) are Name	Condition Dosage	How long
Are you currently under the care of a physician? If yes, what is/are the condition(s) being treated?	Ø 🗆	Prescribed:	one	
Greast cancel				
Date of last physical examination/medical check-up:	2024	N. D. COTTO	1 1	
Primary Care Provider/Specialist/Clinic:	Illman	Non-Prescription (OTC):	Tylenol	3
All E O		Vitamins, natural or herbal preparations and for diet sup	mlamanta: / s	
234-567-8901 CITY/STATE	ZIP	preparations and or diet sup	a Makes	cea,
PHONE	0			
☐ Check if your last medical check-up was outside of U	.5.			Yes No
Have you had any serious illness, operations, or been hospitalized within the past 5 years?	Yes No ✓□ □	Do you consume alcohol re		□ ☆ ○
If yes, what was the problem? Lumpecto	ony.	If yes, how much?		
Movember 200	23/	Do you use drugs or other s recreational purposes?		□ ★
· · · · · · · · · · · · · · · · · · ·		If yes, please list:		
Are you allergic to or have you had a reaction to?	Yes No	Frequency of use (daily, we	ekly, etc.):	
Local or topical anesthetics (like "novocaine") Aspirin	- 2 - 2	Do you use tobacco (smoki	ng/vaping, snuff, chewing)?	□ ½ €
Penicillin or other antibiotics Sulfa drugs		If yes, for how long have you		
Codeine or other narcotics	<u> </u>	(circle one): Very / Some		
Latex Iodine	Z	Have you had an orthopedic	total joint replacement?*	Yes No
Hay fever/seasonal Food (specify)		(hip, knee, elbow) If yes, when was this opera	tion done?	<u>α</u>
Other (specify) Metals (specify)				
To yes responses, specify type of reaction.		Has a physician or dentist r		
113067		you take antibiotics prior to	your dental treatment?	4
		If yes, what antibiotic and o		
		Name of physician or denti	st:	
		Phone:		***************************************
			WOMEN ONLY	
Please complete both sides		Are you or could you be pro		D 80
		Laking Dirip Control bille of		

Place an "X" to indicate if you have or have not had any of the following dis	seases or problems		V N-
	Yes No		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 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* 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: Eating disorder. If yes, specify:	A DOCTOR OF A DOCTOR	Hemophilia* Hepatitis Recurrent infections If yes, indicate type of infection	一种
Eating disorder. If yes, specify. Epilepsy * Fainting spells or seizures Gastrointestinal disease G.E. Reflux/persistent heartburn Glaucoma *Require faculty DDS consultation	despera	listed above that you think we should know about? Please explain:	
	DENTAL INFO	RMATION	
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	Yes Moodooo o	Date of your last dental check-up: What treatment was done at that time? Date of your last oral hygiene services: Date of last dental x-rays: Do you have any additional concerns?	one
City College of Technology, the Dental Hygiene Depar of omission that I may have made when completing this	tment or its' students resp s medical history form. borne Pathogen Policy"	is accurate to the best of my knowledge. I will not hold Nonsible for any action they take or do not take because of for the Dental Hygiene Department. I understand that thind how I can get access to this information.	f errors
PATIENT or LEGAL GUARDIAN SIGNATURE	(sign in clinic)		DATE
Significant findings from oral interview:			ASA:
	* ,		

Date

Medical Alert Alert Condition:	lergy to:	Premedica	tion Needed:	BP:/	F. Chart Marshaut	
				Pulse: bpm	E-Chart Number:	
	NEW YORK CIT	Y COLLI	EGE OF TECHN	OLOGY – HEALTH HIS	STORY FORM	
Name: Caramel L	affe	Ni	Phone: 35	33 497-2105	Email: Caramel a	Ignail. con
Address: LAGT far Balala	S FIRST MID	DDLE INITIAL	City: Co	fee town	State: PA Zip Code:	43012
Occupation: teacher		Height:	5.7 Weig	ht: 185 Date of Birth	h: 7/3//89Gender:	MO FO XO
Emergency Contact: 1 Ced	tea		Relationship	wife	Phone: ()
If you are completing this form for	another person, wh	at is your r	elationship to that			
For the following questions, please (X) whichever a about your responses to this questionnaire and there	pplies. Your answers are for o	our records only	and will be kept confident	NAME ial in accordance with applicable laws. I	RELATIONSHI Please note that during your initial visit you wi	
about your responses to any questionmane and there	may be additional questions e	BURNESTA STATE	MEDICAL INFO		care for you.	
Are you in good health? Has there been any change in your heal	th within past year?	Yes I	1	Are you taking or have you medicine(s) including non-p	recently taken any prescription/OTC/supplements?	Yes No
Do you have a Primary Care Provider/s	specialist?	_ \(\)	â	If yes, what medicine(s) are Name	you taking? Condition Dosage	How long
Are you currently under the care of a p If yes, what is/are the condition(s) bein			á	Prescribed:	-	
						 ن
Date of last physical examination/medi Primary Care Provider/Specialist/Clinic ADDRESS PHONE	L	ZIP	ago —	Non-Prescription (OTC); Vitamins, natural or herbal preparations and/or digt supp	famin D	
☐ Check if your last medical check-u	up was outside of U.S.					Yes No
Have you had any serious illness, opera or been hospitalized within the past 5 y		Yes	No Q	Do you consume alcohol reg	gularly? EE \(\sigma \) How often? \(\mathcal{U} \)	Lee 6 endo
If yes, what was the problem?						
				Do you use drugs or other su recreational purposes?	dostances for	d
Are you allergic to or have you had a re	postion to?	Yes N		If yes, please list:	•• • •	
Local or topical anesthetics (like "novo		N.		Frequency of use (daily, wee Do you use tobacco (smokin		b/ a
Aspirin Penicillin or other antibiotics Sulfa drugs Codeine or other narcotics Latex	came)		1 1 1 1 1 1	If yes, for how long have yo If yes, how interested are yo (circle one): Very / Somew	ou been using tobacco?	
Iodine Hay fever/seasonal Food (specify) Other (specify) Metals (specify)	7 9			Have you had an orthopedic (hip, knee, elbow) If yes, when was this operati		Yes No
To yes responses, specify type of reacti	on. eathe	- 4		Has a physician or dentist re you take antibiotics prior to		□ Þ í
				If yes, what antibiotic and do	ose?	
				Name of physician or dentise Phone:	t:	
					WOLLEN ON THE	
Please complete both sides				Are you or could you be pre	WOMEN ONLY	
\Box \Diamond				Taking birth control pills or		<u> </u>

Place an "X" to indicate if you have or have not had any of the following disease	Free control		Yes No
	Yes No		
Abnormal bleeding	□ <u>}</u>	Hemophilia*	0 0
AIDS or HIV infection		Hepatitis	
Anemia Arthritis/ Rheumatoid arthritis		Recurrent infections If yes, indicate type of infection	
Asthma	□ <u>Þ</u> s	Kidney problems	
Blood transfusion. If yes, date:		Mental health disorders. If yes, specify	
Cancer/chemotherapy/radiation treatment	□ bx	Night sweats Neurological disorders. If yes, specify	
Cardiovascular disease. If yes, specify below:		Osteoporosis	
Angina	□ À	Persistent swollen glands in neck	
High Cholesterol High blood pressure		Respiratory problems. If yes, specify below:	
Artificial heart valves*Low blood pressure Congenital heart defects* Mitral valve prolapse		Emphysema Bronchitis, etc.	3 3
Congestive heart failure* Pacemaker		Severe headaches, migraines	
Coronary heart disease*		Severe or rapid weight loss Sexually transmitted disease	
Damaged heart valves*		Sinus trouble	<u> </u>
Chest pain upon exertion		Sleep disorder	
Chronic pain Disease, drug or radiation-induced immunosuppression		Systemic lupus erythematosus Tuberculosis*	
	/	Thyroid problems	<u> </u>
Diabetes, If yes, specify below:		Ulcers	
Type I (Insulin dependent) Type II	1	Excessive urination	
Eating disorder. If yes, specify:		Do you have any disease, condition or problem not	
Epilepsy *		listed above that you think we should know about?	
Fainting spells or seizures		Please explain:	
Gastrointestinal disease G.E. Reflux/persistent heartburn	\$(0.0.00 0.00 0.00 0.00		,
Glaucoma		4	
*Require faculty DDS consultation	.81 - 2		
	DENTAL INFOR	MATION	
	45 F 14 F 24 F 36 F 36 F 36 F 37 F 37		
	Yes No		
Do your gums bleed when you brush?	Yes No		
Do you have dry mouth? Have you had orthodontic treatment (braces/alignments)?	Yes No	How would you describe your current dental health?	
Do you have dry mouth? Have you had orthodontic treatment (braces/alignments)? Are your teeth sensitive to cold, hot, sweets or pressure?	Yes No	How would you describe your current dental health?	
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?	Yes No	How would you describe your current dental health?	
Do you have dry mouth? Have you had orthodontic treatment (braces/alignments)? Are your teeth sensitive to cold, hot, sweets or pressure?	Yes No	How would you describe your current dental health? Good Chock Sh Date of your last dental check-up: More flow What treatment was done at that time? Dulled	4 Syears a
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?	Yes No	How would you describe your current dental health?	4 Syears a
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	T	ri-	T == -		
Medical Alert Condition:	Allergy to:	Premedication Needed: □ Yes □ No	BP:/	E-Chart Number:	
	NEW YORK CIT	Y COLLEGE OF TECH	Pulse: bpm	STORY FORM	
	(D	r collide or them		STORT TORM	
Name Vanlla	Bean	Phone: (3,456-7-290	Email: V. Bean @ g.	mail
Address: LAST Nerry	FIRST MID	City: But	oble tea	State: Zip Code:	200000
Occupation:	111 1	Height: 6 - 1 Wei	ght: Date of Birt	th: 9/1/78 Gender:	: Me FO XO
Emergency Contact: VW	illa Cook	Relationship	mother	Phone: (_)
If you are completing this form	for another person, wh	at is your relationship to the	at person?	* ***	
				RELATIONSHI Please note that during your initial visit you wi	
about your responses to this questionnaire and	there may be additional questions c	oncerning your health. This information MEDICAL INFO	ADDRESS (1995)	e care for you.	
		Yes No	Are you taking or have you	recently taken any	Yes No
Are you in good health? Has there been any change in your	health within past year?		medicine(s) including non-	prescription/OTC/supplements?	
Do you have a Primary Care Provide	der/specialist?	a a	If yes, what medicine(s) are Name	e you taking? Condition Dosage	How long
Are you currently under the care of If yes, what is/are the condition(s)		- -	Prescribed Celeb	rex for pa	19
Date of last physical examination/r	a B	12 124	Non-Prescription (OTC):		
Primary Care Provider/Specialist/C	Clinic Ar 19as	33	Vitamins, natural or herbal	<u> </u>	
ADDRESS CONTRACTOR	CITY/STATE	ZIP	preparations and/or diet sup	oplements:	
111-23-456 PHONE	14				
☐ Check if your last medical che	eck-up was outside of U.S.				Yes No
Have you had any serious illness, or or been hospitalized within the pas	operations,	Yes No	Do you consume alcohol re		□ þc
If yes, what was the problem?	had a h	lp / ,	If yes, how much?	How often?	
refstaceine	ut fulc	e (2018) and	Do you use drugs or other s recreational purposes?		
(400	(4)		If yes, please list:		
Are you allergic to or have you had	l a reaction to?	Yes No	Frequency of use (daily, we		<u> </u>
Local or topical anesthetics (like "r Aspirin	novocaine")	00000000000000000000000000000000000000	Do you use tobacco (smoki	ing/vaping, snuff, chewing)?	X ·
Penicillin or other antibiotics		00000000000000000000000000000000000000	If yes, for how long have your If yes, how interested are y	ou been using tobacco?	
Sulfa drugs Codeine or other narcotics		□ \ <u>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </u>	(circle one): Very / Some		
Latex Iodine		A D	Have you had an orthopedi	c total joint replacement?*	Yes No
Hay fever/seasonal		<u> </u>	(hip, knee, elbow)	1 0 1	
Food (specify) Other (specify)			If yes, when was this opera	tion done?	226
Metals (specify)		i 🏂	-		
To yes responses, specify type of re	eaction.		Has a physician or dentist r you take antibiotics prior to		80
*		-	If yes, what antibiotic and o	dose? 1 dout	Luou -
			Name of physician or denti	·	
			Phone:		
			CHARLES AND AND THE COMMON TO	WOMEN ON V	
Please complete both sides			Are you or could you be pr	WOMEN ONLY	
$\sqcap \Delta$			Taking birth control pills or		

updated-2024

Place an "X" to indicate if you have or have not had any of the following dise	ases or problems		Yes No
	Yes No		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	1	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	400 000 00 0 0000000000000000000000000
Eating disorder. If yes, specify: Epilepsy * Fainting spells or seizures Gastrointestinal disease G.E. Reflux/persistent heartburn Glaucoma *Require faculty DDS consultation	00000 00000	Do you have any disease, condition or problem not listed above that you think we should know about? Please explain:	
	DENTAL INFOR	MATION	
	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 CMSHM CO	0 00000 de	Date of your last dental check-up: What treatment was done at that time? Date of your last oral hygiene services: Date of last dental x-rays: #of images? Do you have any additional concerns?	2 4 reeus
City College of Technology, the Dental Hygiene Departr of omission that I may have made when completing this	nent or its' students respo medical history form. orne Pathogen Policy" fo	accurate to the best of my knowledge. I will not hold New nsible for any action they take or do not take because of error the Dental Hygiene Department. I understand that this not how I can get access to this information.	ors
PATIENT or LEGAL GUARDIAN SIGNATURE	(sign in clinic)	n	ATE
	(B		
Significant findings from oral interview:			ASA:
*			_

Date

Medical Alert Condition: Allergy to:	Premedication Needed: □ Yes □ No	BP:/	E-Chart Number:	
		Pulse: bpm		*EMPRESSION SERVICES
NEW YORK CIT	Y COLLEGE OF TECH	NOLOGY – HEALTH HI	STORY FORM	
Name: Rasubow Sprinkles	Phone:	13 456-7890	Email Caruloon Co	yalioo.co
	Dad City a	ndy Land	State: NY Zip Cod	e: 11111
Occupation: Raker	Height: 4 11 We	ight: 165 Date of Birt	h: 01/01/95 Gend	der: MO NO XO
Emergency Contact Marliolote Stor	Jubles Relationshi		Phone: ()
If you are completing this form for another person, who	NA	**************************************	T Hone. (
For the following questions, please (X) whichever applies. Your answers are for c		NAME	RELATION	
about your responses to this questionnaire and there may be additional questions c	concerning your health. This information	n is vital to allow us to provide appropriate		1 will be asked some question.
	MEDICAL INF	ORMATION		(多) (1) (1) (1) (1)
Are you in good health? Has there been any change in your health within past year?	Yes No		prescription/OTC/supplements?	Yes No
Do you have a Primary Care Provider/specialist?	, p(`□	If yes, what medicine(s) are Name	you taking? Condition Dosage	How long
Are you currently under the care of a physician? If yes, what is/are the condition(s) being treated?	<u> </u>	Prescribed: TO parl	ax myrorue	8 50 mg
. 1	17	20300100	11091131000	presoure 1
Date of last physical examination/medical check-up:	17/24 2000	Non-Prescription (OTC):	INP	
Primary Care Provider/Specialist/Clinic: N CEC	10001	Vitamins, natural or herbal preparations and/or diet sup	oplements:	
DEPHONE 123-7567	ZIP	Zone,	llderberr	
☐ Check if your last medical check-up was outside of U.S.			0	Yes No
Have you had any serious illness, operations, or been hospitalized within the past 5 years?	Yes No	Do you consume alcohol re	gularly? asses of wine How often?	1 week
Off yes, what was the problem? Outaract Surgery	14 Februar	Do you use drugs or other s recreational purposes?	2-01-02-003 (27-02-004-04-04-04-04-04-04-04-04-04-04-04-04	
0 ()	(If yes, please list:	9	
Are you allergic to or have you had a reaction to?	Yes No	Frequency of use (daily, we	eekly, etc.):	
Local or topical anesthetics (like "novocaine") Aspirin		Do you use tobacco (smoki	ng/vaping, snuff, chewing)?	- X
Penicillin or other antibiotics	⊠ □	If yes, for how long have ye		(
Sulfa drugs Codeine or other narcotics		If yes, how interested are ye (circle one): Very / Some		
Latex (odine		Have you had an orthopedic	c total joint replacement?*	Yes No
Hay fever/seasonal	9 0	(hip, knee, elbow)		□ \$Z
Other (specify)	1 0	If yes, when was this opera	tion done?	
Metals (specify) To yes responses, specify type of reaction		Has a physician or dentist r you take antibiotics prior to		- <u>(</u>
7-5-1		If yes, what antibiotic and c	lose?	ţ
		Name of physician or denti		
		Phone:		
Please complete both sides			WOMEN ONLY	
		Are you or could you be pro		

Place an "X" to indicate if you have or have not had any of the following di	seases or problems		ž.	900000000000
	Yes No			Yes No
	1			
Abnormal bleeding	□ b €		Hemophilia*	
AIDS or HIV infection	<u> </u>		Hepatitis	
Anemia			Recurrent infections	□ / 2 ·
Arthritis/ Rheumatoid arthritis			If yes, indicate type of infection	F
Asthma Blood transfusion. If yes, date:			Kidney problems	
Blood transfusion. If yes, date:	سم ت		Mental health disorders. If yes, specify	
Cancer/chemotherapy/radiation treatment	□ ½		Night sweats	1 /U
cuitori dicinolitati pyrradianon dicinicino			Neurological disorders. If yes, specify Osteoporosis	□ /5 .
Cardiovascular disease. If yes, specify below:			Persistent swollen glands in neck	
Angina	1		r ersistent sworten glands in neek	7/6
High Cholesterol High blood pressure			D 10 10 10 10 10 10 10 10 10 10 10 10 10	- 4
Artificial heart valves* / Low blood pressure			Respiratory problems. If yes, specify below: Emphysema Bronchitis, etc.	
Congenital heart defects* Mitral valve prolapse			Severe headaches, migraines	XI 🗆
Congestive heart failure* Pacemaker Coronary heart disease*			Severe or rapid weight loss)zi 🖸
Damaged heart valves*			Sexually transmitted disease	o o o o o o o o o o o o o o o o o o o
Damaged neart varves			Sinus trouble	
Chest pain upon exertion			Sleep disorder	
Chronic pain	0 (SE		Systemic lupus erythematosus	
Disease, drug or radiation-induced immunosuppression	□ <i>2</i>		Tuberculosis*	
D' 1	6 0		Thyroid problems	
Diabetes, If yes, specify below: Type I (Insulin dependent)	X □ □		Ulcers	
Type II Most Recent HbA1c Value:	1		Excessive urination	
			Do you have any disease, condition or problem not	
Eating disorder. If yes, specify:			listed above that you think we should know about?	
Epilepsy *			isted doore that you tillik we should know about.	
Fainting spells or seizures			Please explain:	
Gastrointestinal disease				
G.E. Reflux/persistent heartburn Glaucoma				
	u u			
*Require faculty DDS consultation			a contract of the contract of	
	DENT	AL INFORM	MATION	
	DENT	AL INFOR	MATION	
	Yes No			
Do your gums bleed when you brush?	6 a		How would you describe your current dental health?	
Do you have dry mouth?			110+ 9000	
Have you had orthodontic treatment (braces/alignments)?	<u> </u>			
Are your teeth sensitive to cold, hot, sweets or pressure?	\(\begin{array}{c} \omega & \text{o} & \tex		1/2020	
Do you have earaches or neck pains?			Date of your last dental check-up:	
Do you have dental implants?	□ <u>(@</u>		What treatment was done at that time? Wearwy	x-rays
			Date of your last oral hygiene services: 7//2	
Have you had any periodontal (gum) treatments?	4.0			
Do you wear removable dental appliances?				<u>@</u>
Do you wear removable dental appliances? Do you experience bad breath?			Date of last dental x-rays: #of images?	
Do you wear removable dental appliances? Do you experience bad breath? Have you had a serious/difficult problem associated			Date of last dental x-rays: 7/120 #of images?	
Do you wear removable dental appliances? Do you experience bad breath?				<u>~</u>
Do you wear removable dental appliances? Do you experience bad breath? Have you had a serious/difficult problem associated		, a a	Date of last dental x-rays: 7/120 #of images?	<u></u>
Do you wear removable dental appliances? Do you experience bad breath? Have you had a serious/difficult problem associated with any previous dental treatment?		, w	Date of last dental x-rays: 7/120 #of images?	<u></u>
Do you wear removable dental appliances? Do you experience bad breath? Have you had a serious/difficult problem associated with any previous dental treatment?			Date of last dental x-rays: 7/120 #of images?	<u>-</u>
Do you wear removable dental appliances? Do you experience bad breath? Have you had a serious/difficult problem associated with any previous dental treatment?			Date of last dental x-rays: 7/120 #of images?	<u></u>
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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 I certify that I have read, understand and completed thi City College of Technology, the Dental Hygiene Depart of omission that I may have made when completing thi I have received the "Notice of Privacy Practice/Blood describes how medical/dental information about me made I consent to having a dental hygiene examination. PATIENT or LEGAL GUARDIAN SIGNATURE	s medical histortment or its' st s medical historthere Pathog ay be used and	en Policy" for disclosed and	Date of last dental x-rays: 7/20 #of images? Do you have any additional concerns? accurate to the best of my knowledge. I will not hold New insible for any action they take or do not take because of error the Dental Hygiene Department. I understand that this not how I can get access to this information.	otice
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 I certify that I have read, understand and completed thi City College of Technology, the Dental Hygiene Depart of omission that I may have made when completing thi I have received the "Notice of Privacy Practice/Blood describes how medical/dental information about me made I consent to having a dental hygiene examination. PATIENT or LEGAL GUARDIAN SIGNATURE	s medical histortment or its' st s medical historthere Pathog ay be used and	en Policy" for disclosed and	Date of last dental x-rays: 7/20 #of images? Do you have any additional concerns? accurate to the best of my knowledge. I will not hold New insible for any action they take or do not take because of error the Dental Hygiene Department. I understand that this not how I can get access to this information.	otice
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 I certify that I have read, understand and completed thi City College of Technology, the Dental Hygiene Depart of omission that I may have made when completing thi I have received the "Notice of Privacy Practice/Blood describes how medical/dental information about me made I consent to having a dental hygiene examination. PATIENT or LEGAL GUARDIAN SIGNATURE	s medical histortment or its' st s medical historthere Pathog ay be used and	en Policy" for disclosed and	Date of last dental x-rays: 7/20 #of images? Do you have any additional concerns? accurate to the best of my knowledge. I will not hold New insible for any action they take or do not take because of error the Dental Hygiene Department. I understand that this not how I can get access to this information.	otice

Date

Medical Alert Allergy to:	Premedication Needed:	DD.		
Medical Alert Allergy to: Condition:	□ Yes □ No	BP:/	E-Chart Number:	
		Pulse: bpm		
NEW YORK CIT	Y COLLEGE OF TECHN	NOLOGY – HEALTH HIS	STORY FORM	
Name Chocolate Chip	Phone Ho	2812 2212	Email: clup @ gn	rail
Address: 200 Joy Street MID	DLE INITIAL 1	22602.	State: NY Zip Code:	10001
Occupation: Pecel Fity	Height: 6-2 Weight	eht:/90 Date of Birtl	01//09	10
Emergency Contact: Cherry Cola		01 11 -10 6 1	-/ / /	10 1.04 700
Emergency Contact.	Relationship	0	Phone: (31100 /8/
If you are completing this form for another person, wh	•	NAME	RELATIONS	HIP
For the following questions, please (X) whichever applies. Your answers are for or about your responses to this questionnaire and there may be additional questions or	oncerning your health. This information	is vital to allow us to provide appropriate	care for you.	/ill be asked some questions
	MEDICAL INFO	ORMATION		
Are you in good health? Has there been any change in your health within past year?	Yes No	Are you taking or have you medicine(s) including non-p	recently taken any rescription/OTC/supplements?	Yes No
Do you have a Primary Care Provider/specialist?	И п	If yes, what medicine(s) are Name	you taking? Condition Dosage	How long
	2 0	Prescribed!	Condition Dosage	110W long
Are you currently under the care of a physician? If yes, what is/are the condition(s) being treated?		ACPIT!	Sling	8
		Atorvast	atin 5	me
06	log by	1 Amlodi	The 10 mg	for High
Date of last physical examination/medical check-up:	107/07	Non-Prescription (OTC):	U	
Primary Care Provider/Specialist/Clinic:		Vitamins, natural or herbal		
23 Holly wood Blvd. CA 9	10210	preparations and/or diet sup	plements:	
ADDRESS CITY/STATE	ZIP	1/14	P _	
PHONE		V / / .		
Check if your last medical check-up was outside of U.S.				Yes No
Have you had any serious illness, operations,	Yes No	Do you consume alcohol reg	gularly?	- X
or been hospitalized within the past 5 years?	\ Z =	If yes, how much?	How often?	
tyes, what was the problem? Heart Surg	in 2023	Do you use drugs or other su recreational purposes?	abstances for	
		If yes, please list:		
Are you allergic to or have you had a reaction to?	Yes No	Frequency of use (daily, wee	ekly, etc.):	
Local or topical anesthetics (like "novocaine") Aspirin	D M	Do you use tobacco (smokin	g/vaping, snuff, chewing)?	X
Penicillin or other antibiotics		If yes, for how long have yo	u been using tobacco?	year
Sulfa drugs Codeine or other narcotics		If yes, how interested are yo (circle one): Very / Somew	hat / Not interested	1
atex odine	□ Ø _V	Have you had an orthopedic	total joint replacement?*	Yes No
Hay fever/seasonal Food (specify)	<u> </u>	(hip, knee, elbow) If yes, when was this operati	•	□ (b /
Other (specify)		ii yes, when was this operati	on done?	2
Metals (specify) Follows responses, specify type of reaction.		Has a physician or dentist re	commended that	
Difficulty breather	4	you take antibiotics prior to	your dental treatment?	
01.		If yes, what antibiotic and do	ose?	
		Name of physician or dentis		
_ *		Phone:		-,-
				TOTAL SECTION AND AND AND AND AND AND AND AND AND AN
Please complete both sides			WOMEN ONLY	
		Are you or could you be pregative Taking birth control pills or		

Place an "X" to indicate if you have or have not had any of the following disease	es or problems		V N-
	Yes No		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* Chest pain upon exertion Chronic pain Disease, drug or radiation-induced immunosuppression Diabetes, If yes, specify below: Type I (Insulin dependent)		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	00000000000000000000000000000000000000
Type II Most Recent HbA1c Value:			
Eating disorder. If yes, specify:		Do you have any disease, condition or problem not listed above that you think we should know about? Please explain:	
	DENTAL INFORM	MATION	
		MATION	
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	Yes No	Date of your last dental check-up: What treatment was done at that time? Date of your last oral hygiene services: Date of last dental x-rays: Do you have any additional concerns?	
I certify that I have read, understand and completed this no City College of Technology, the Dental Hygiene Department of omission that I may have made when completing this no I have received the "Notice of Privacy Practice/Bloodbed describes how medical/dental information about me may I consent to having a dental hygiene examination.	ent or its' students respondical history form. rne Pathogen Policy" form.	nsible for any action they take or do not take because of en or the Dental Hygiene Department. I understand that this n	rrors
PATIENT or LEGAL GUARDIAN SIGNATURE	(sign in clinic)	I	DATE
Significant findings from oral interview:			ANTHOR SOCIETY STANSARD
			ASA:
	·		ASA:
	·		ASA:

Date

Medical Alert Allergy t	o: Premedication	n Needed:	BP:/	1	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
Condition:	□ Yes □ No)	Pulse:bpm_	E-Chart Number:	
NEV	V YORK CITY COLLEG	E OF TECH	NOLOGY – HEALTH HIS	STORY FORM	
Emergency Contact: Casp Berry f you are completing this form for another the following questions, please (X) whichever applies.	our answers are for our records only and	Relationship to the	ight: 175 Date of Birtlip 8 DOUSE nat person? NAME ential in accordance with applicable laws.	Phone: RELATION Please note that during your initial visit yo	de: 1201 der: MD F XD XD HS) 00202
bout your responses to this questionnaire and there may be		AND RESIDENCE OF STATE	n is vital to allow us to provide appropriate ORMATION	care for you.	
Are you in good health? Has there been any change in your health with Do you have a Primary Care Provider/special Are you currently under the care of a physicial f yes, what is/are the condition(s) being treat	ist? 💆 🗆		Are you taking or have you medicine(s) including non-p If yes, what medicine(s) are Name Prescribed: Albertuero Fly drocor	prescription/OTC/supplements?	Yes No How long
Primary Care Provider/Specialist/Clinic: ADDRESS PHONE	Broobly NY (1) EITY/STATE ZIP	_ 200	Non-Prescription (OTC): Vitamins, natural or herbal preparations and/or diet sup	plements:	
Check if your last medical check-up was Have you had any serious illness, operations, or been hospitalized within the past 5 years? f yes, what was the problem?	outside of U.S. Yes No	 	Do you consume alcohol reg If yes, how much? Do you use drugs or other so recreational purposes?	eer How often?	Yes No Weekly
		_	If yes, please list:		
Are you allergic to or have you had a reaction Local or topical anesthetics (like "novocaine" Aspirin Penicillin or other antibiotics Sulfa drugs Codeine or other narcotics			Do you use tobacco (smokir	ou been using tobacco?ou in stopping?	<u> </u>
_atex odine Hay fever/seasonal Food (specify) Dther (specify) Metals (specify)			Have you had an orthopedic (hip, knee, elbow) If yes, when was this operat		Yes No
To yes responses, specify type of reaction.		_	Has a physician or dentist re you take antibiotics prior to		- -
- 1				lose?	
Please complete both sides			Are you or could you be pre		- Jan 19 19 19 19 19 19 19 19 19 19 19 19 19

Place an "X" to indicate if you have or have not had any of the following dis	eases or p	problems		
	Yes	s No		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	Ye		Hemophilia* Hepatitis Recurrent infections If yes, indicate type of infection	4
Disease, drug or radiation-induced immunosuppression		\$	Tuberculosis*	
Distance IC and it is			Thyroid problems	
Diabetes, If yes, specify below:Type I (Insulin dependent)		Z	Ulcers Excessive urination	00000
Type II Most Recent HbA1c Value:				,
Eating disorder. If yes, specify:		由口村国家在	Do you have any disease, condition or problem not listed above that you think we should know about? Please explain: ### ACTION OF THE PROPERTY OF THE PROPER	<u>%</u> -
		DENITAL INFORM	ALTION	
	State of the	DENTAL INFORM	MATION	
City College of Technology, the Dental Hygiene Depar of omission that I may have made when completing this I have received the "Notice of Privacy Practice/Blood describes how medical/dental information about me ma	medic tment c medic	or its' students responsial history form. Pathogen Policy" form.	Date of your last dental check-up: What treatment was done at that time? Date of your last oral hygiene services: Wo years Date of last dental x-rays: Do you have any additional concerns? Do you have any additional concerns? accurate to the best of my knowledge. I will not hold New nsible for any action they take or do not take because of end they are the Dental Hygiene Department. I understand that this not how I can get access to this information.	ago gago york
I consent to having a dental hygiene examination.	,		The state of the s	
PATIENT OF LEGAL GUARDIAN SIGNATURE	(sie	gn in clinic)	n	ATE
PATIENT or LEGAL GUARDIAN SIGNATURE	(sig	gn in clinic)	D	ATE
	(sig	gn in clinic)		
PATIENT or LEGAL GUARDIAN SIGNATURE Significant findings from oral interview:	(sig	gn in clinic)		ATE ASA:
	(sig	gn in clinic)		
	(sig	gn in clinic)		

Date