East Tennessee State University
College of Clinical and Rehabilitative Health Sciences
Dental Hygiene Program
Johnson City, TN 37614-1709

Medical History

Medical Alerts

Date _____

Name _____ (LAST / FIRST / MIDDLE) Home Phone (____) _____

Address _____ (NUMBER, STREET) Business Phone (____) _____

City _____ State _____ Zip Code _____

Occupation _____

Date of Birth ___/___/___ (MO / DAY / YR) Sex: M F Height _____ Weight _____

Person to contact in case of emergency _____ Phone (____) _____

If the person listed above is a minor, is permission granted for: X-rays: ❑ Yes ❑ No **and/or Sealants:** ❑ Yes ❑ No

Parent/Guardian Signature _____

The following questionnaire must be completed before any treatment is rendered. The information is for our records and is considered confidential.

Describe your current dental problem: _____

1. Have you or your family recently experienced any of the following medical conditions?:
   a. TB ..... Yes No
   b. Fever ..... Yes No
   c. Night sweats ..... Yes No
   d. Persistent cough that produces blood ..... Yes No
   e. Unexplained weight loss ..... Yes No

ORAL HEALTH

2. The name and city of my dentist is:
   _____
   _____
   _____
3. The name and city of my physician(s) is:
   _____
   _____
   _____
4. Are you currently having any dental problems? ..... Yes No
5. Have you ever been treated for Periodontal Disease (gum disease, pyorrhea, trench mouth)? ..... Yes No
6. Do your gums ever bleed when you brush, floss, or for no apparent reason? ..... Yes No
7. Have you ever been shown proper brushing and flossing techniques? ..... Yes No
8. Do you use any oral cleansing mechanisms in addition to a toothbrush and floss? ..... Yes No
9. How often do you brush? _____
10. How often do you floss? _____
11. Do you have sores, swellings, or blisters on your gums, cheeks or lips? ..... Yes No
12. Have you had orthodontic treatment? ..... Yes No
13. Have you had any serious trouble associated with any previous dental treatment? ..... Yes No
    If so, explain: _____
    _____
    _____
14. Are you wearing removable dental appliances? ..... Yes No
15. Dental treatment history:
    a. Last dental visit _____
    b. Last dental x-rays _____
    c. Last cleaning _____
16. Are you in good health? ..... Yes No
17. Has there been any change in your general health within the past year? ..... Yes No
18. My last physical examination was on _____
19. Are you now under the care of a physician? ..... Yes No
    If so, what is the condition being treated? _____
    _____
    _____
20. Have you had any serious illness, operation, or hospitalization? ..... Yes No
    If so, what was the illness or problem? _____
    _____
    _____
21. Have you used tobacco products within the past year? Yes No
22. Do you have or have you had any of the following diseases or conditions?
    a. Allergy ..... Yes No
    b. Arthritis or painful swollen joints ..... Yes No
    c. Asthma ..... Yes No
    d. Cancer ..... Yes No
    e. Cardiovascular disease (heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, congestive heart failure) ..... Yes No
       1. Do you have chest pain upon exertion? ..... Yes No
       2. Are you ever short of breath after mild exercise or when lying down? ..... Yes No
       3. Do your ankles swell? ..... Yes No
       4. Do you have congential heart defects? If so explain _____ Yes No
       5. Do you have a cardiac pacemaker? ..... Yes No
       6. Do you have artificial heart valves or have you had a heart transplant? ..... Yes No
       7. Do you have a history of infective endocarditis? Yes No
    f. Stroke? ..... Yes No
    g. Diabetes: what type? _____ ..... Yes No
       1. Slow-healing cuts ..... Yes No
       2. Frequent thirst ..... Yes No
       3. Frequent urination (more than 6 times/day) ..... Yes No
       4. Increase in appetite with no weight gain ..... Yes No
    h. Epilepsy, seizures, or other neurological disease ... Yes No
    i. Fainting spells ..... Yes No

Continue on Back

j. Hepatitis, jaundice or liver disease........................ Yes No
k. HIV or AIDS infection.. Yes No
l. Joint replacement... Yes No
m. Kidney trouble .... Yes No
n. Low blood pressure... Yes No
o. Persistent diarrhea or recent weight loss .... Yes No
p. Persistent swollen glands in neck .... Yes No
q. Problems of the immune system........................... Yes No
r. Problems with mental health .... Yes No
s. Respiratory problems, emphysema, bronchitis, etc. .... Yes No
t. Sexually transmitted disease................................ Yes No
u. Sinus trouble or hay fever..................................... Yes No
v. Stomach ulcer, hyperacidity or gastric reflux .... Yes No
w. Thyroid problems.. Yes No
x. Chronic pain .... Yes No
y. Eating disorder .... Yes No

23. Have you had abnormal bleeding?............................. Yes No
    a. Have you ever required a blood transfusion?......... Yes No

24. Do you have any blood disorder such as anemia?...... Yes No

25. Have you ever had any treatment for a tumor or growth?... Yes No

26. Are you allergic or have you had a reaction to:
    a. Aspirin?.. Yes No
    b. Barbiturates, sedatives, or sleeping pills?............. Yes No
    c. Codeine or other narcotics?................................. Yes No
    d. Iodine?.. Yes No
    e. Local anesthetics?... Yes No
    f. Penicillin or other antibiotics? .... Yes No
    g. Sulfa drugs? .... Yes No
    h. Latex?... Yes No
    i. Other?... Yes No

27. Do you have any disease, condition, or problem not listed above that you think I should know about? ...... Yes No
    If so, explain ______________________________
    ____
    ____

Women:

28. Are you pregnant? .... Yes No

29. Do you have any problems associated with your menstrual period?... Yes No

30. Are you nursing?... Yes No

31. Are you taking birth control pills? .... Yes No

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold ETSU, or any other member of this staff, responsible for any errors or omissions that I may have made in the completion of this form.

Blood Pressure ______________________________

Respiration ______________________________

Pulse ______________________________

Temperature ______________________________

Blood Glucose/HbA1c ______________________________

____
SIGNATURE OF PATIENT

____
SIGNATURE OF STUDENT

____
SIGNATURE OF INSTRUCTOR

Please list all medications / herbal remedies that you are taking:

DRUG	CLASSIFICATION	DENTAL CONSIDERATION

Patient Name: ______________________________
LAST FIRST MIDDLE

Vital Sign Updates: DATE	**Vital Sign Updates:** DATE	**Vital Sign Updates:** DATE
BLOOD PRESSURE / PULSE	BLOOD PRESSURE / PULSE	BLOOD PRESSURE / PULSE
RESPIRATION / TEMPERATURE	RESPIRATION / TEMPERATURE	RESPIRATION / TEMPERATURE
HbA1c / BLOOD GLUCOSE	HbA1c / BLOOD GLUCOSE	HbA1c / BLOOD GLUCOSE
STUDENT SIGNATURE / INSTRUCTOR SIGNATURE	STUDENT SIGNATURE / INSTRUCTOR SIGNATURE	STUDENT SIGNATURE / INSTRUCTOR SIGNATURE
UPDATES/PATIENT SIGNATURE	UPDATES/PATIENT SIGNATURE	UPDATES/PATIENT SIGNATURE
Vital Sign Updates: DATE	**Vital Sign Updates:** DATE	**Vital Sign Updates:** DATE
BLOOD PRESSURE / PULSE	BLOOD PRESSURE / PULSE	BLOOD PRESSURE / PULSE
RESPIRATION / TEMPERATURE	RESPIRATION / TEMPERATURE	RESPIRATION / TEMPERATURE
HbA1c / BLOOD GLUCOSE	HbA1c / BLOOD GLUCOSE	HbA1c / BLOOD GLUCOSE
STUDENT SIGNATURE / INSTRUCTOR SIGNATURE	STUDENT SIGNATURE / INSTRUCTOR SIGNATURE	STUDENT SIGNATURE / INSTRUCTOR SIGNATURE
UPDATES/PATIENT SIGNATURE	UPDATES/PATIENT SIGNATURE	UPDATES/PATIENT SIGNATURE
Vital Sign Updates: DATE	**Vital Sign Updates:** DATE	**Vital Sign Updates:** DATE
BLOOD PRESSURE / PULSE	BLOOD PRESSURE / PULSE	BLOOD PRESSURE / PULSE
RESPIRATION / TEMPERATURE	RESPIRATION / TEMPERATURE	RESPIRATION / TEMPERATURE
HbA1c / BLOOD GLUCOSE	HbA1c / BLOOD GLUCOSE	HbA1c / BLOOD GLUCOSE
STUDENT SIGNATURE / INSTRUCTOR SIGNATURE	STUDENT SIGNATURE / INSTRUCTOR SIGNATURE	STUDENT SIGNATURE / INSTRUCTOR SIGNATURE
UPDATES/PATIENT SIGNATURE	UPDATES/PATIENT SIGNATURE	UPDATES/PATIENT SIGNATURE
Vital Sign Updates: DATE	**Vital Sign Updates:** DATE	**Vital Sign Updates:** DATE
BLOOD PRESSURE / PULSE	BLOOD PRESSURE / PULSE	BLOOD PRESSURE / PULSE
RESPIRATION / TEMPERATURE	RESPIRATION / TEMPERATURE	RESPIRATION / TEMPERATURE
HbA1c / BLOOD GLUCOSE	HbA1c / BLOOD GLUCOSE	HbA1c / BLOOD GLUCOSE
STUDENT SIGNATURE / INSTRUCTOR SIGNATURE	STUDENT SIGNATURE / INSTRUCTOR SIGNATURE	STUDENT SIGNATURE / INSTRUCTOR SIGNATURE
UPDATES/PATIENT SIGNATURE	UPDATES/PATIENT SIGNATURE	UPDATES/PATIENT SIGNATURE