VERMONT TECH	DEPARTMENT OF DENTAL HYGIENE

DATE: _____ **DATE OF BIRTH:** _____

NAME: _____ **EMAIL ADDRESS:** _____

ADDRESS: _____
Street or PO Box *Town/City* *State* *Zip code*

TELEPHONE: **H:** _____ **W:** _____ **C:** _____

GENDER: □ **M** □ **F** **REFERRED BY:** _____

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME: _____ **RELATIONSHIP:** _____

TELEPHONE: **H:** _____ **W:** _____ **C:** _____

MEDICAID INSURANCE INFORMATION – IF APPLICABLE

MEDICAID ID NUMBER: _____
(Not Medicare)

MEDICAL PROVIDER:

PHYSICIAN'S NAME: _____ **ADDRESS:** _____

TELEPHONE: _____ **DATE OF LAST VISIT:** _____ **REASON FOR VISIT:** _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? □ **YES** □ **NO** **IF YES, EXPLAIN:** _____

_____

DO YOU REQUIRE AN ANTIBIOTIC PRIOR TO DENTAL TREATMENT? (For specific heart conditions or artificial joints) □ **YES** □ **NO**

ARE YOU CURRENTLY TAKING ANY PRESCIBED OR OVER-THE-COUNTER MEDICATIONS OR SUPPLEMENTS? □ **YES** □ **NO**

If yes, please provide the name and dose of each medication:

_____

_____

DO YOU HAVE A HISTORY OF EXPOSURE TO ANY MEDICAL X-RAYS (INCLUDING RADIATION THERAPY)? □ **YES** □ **NO**

If yes, please provide: **Date:** _____ **Type:** _____

Patient Name: _____

DENTAL PROVIDER:

DENTIST'S NAME: _____ **ADDRESS:** _____

TELEPHONE: _____ **DATE OF LAST VISIT:** _____ **REASON FOR VISIT:** _____

HISTORY OF DENTAL X-RAYS: **Date:** _____ **Type:** _____

ORAL HYGIENE HABITS:

TOOTHBRUSH TEXTURE: □ **Hard** □ **Medium** □ **Soft** **TYPE OF TOOTHBRUSH:** □ **Manual** □ **Electric**

Frequency of brushing: _____ **Frequency of flossing:** _____ **Use of other dental devices:** □ **YES** □ **NO**

If you answered yes, please describe the type of dental device you are using and the frequency of use:

_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (circle YES or NO and provide an explanation if appropriate)

A RESPONSE OF YES TO ANY OF THE QUESTIONS MARKED WITH ** REQUIRES CONSULTATION AND DOCUMENTATION FROM PHYSICIAN PRIOR TO TREATMENT

ORAL CAVITY

Yes No Tooth sensitivity to hot, cold or sweets? _____

Yes No Bleeding gums? If yes, for how long? _____

Yes No Clenching or grinding? If yes, do you wear a night guard or splint? _____

Yes No Lumps or swelling in the mouth? If yes, where? _____

Yes No Pain or sounds around ears? _____

Yes No Complications from extractions? _____

Yes No Periodontal treatment? If yes, when? _____

Yes No History of oral cancer? If yes, when and location? _____

Yes No Orthodontic treatment? If yes, when? _____

Yes No Oral habits (cheek biting, tongue biting, etc.)? _____

Yes No Halitosis (bad breath)? _____

CARDIOVASCULAR SYSTEM

Yes ** **No History of infective endocarditis (sub-acute bacterial endocarditis)?** _____

Yes ** **No Congenital heart disease? If yes, describe** _____

Yes ** **No Any valvular defects and/or an artificial heart valve?** _____

Yes No Irregular heart beat or arrhythmia? _____

Yes No Myocardial infarction (heart attack)? _____

Yes No Congestive heart disease? _____

Yes No Cerebrovascular accident (stroke)? _____

Yes No Angina? _____

Yes No High or low blood pressure? _____

Patient Name: _____

CARDIOVASCULAR SYSTEM *continued*		
Yes	No	Cardiac by-pass surgery? _____
Yes**	No	Heart transplant? If yes, when? _____
Yes	No	Implanted pacemaker or defibrillator? _____
Yes	No	Swollen ankles? _____

RESPIRATORY SYSTEM		
Yes	No	Lung disease, emphysema, bronchitis, COPD? If yes, explain: _____
Yes	No	Asthma? If yes, do you use an inhaler? _____
Yes	No	Sleep apnea? If yes, describe treatment if applicable _____
Yes	No	Hay fever and/or environmental allergies? _____
Yes	No	Sinus problems? _____
Yes	No	Tuberculosis? If yes, indicate age _____
Yes	No	Family member with tuberculosis? If yes, indicate age _____
Yes	No	Chronic cough, hoarseness, sore throat, or cough that produces blood? _____
Yes	No	Scarlett fever, pneumonia, and/or high fever disease? _____
Yes	No	Nicotine/Tobacco habit (any form of tobacco or e-cigarette? If yes, how long, how much, how often? _____ _____

CENTRAL NERVOUS SYSTEM		
Yes	No	Multiple Sclerosis? _____
Yes	No	Parkinson's disease? _____
Yes	No	Seizure disorder or convulsions? _____
Yes	No	Problems associated with a stroke? _____
Yes	No	Trembles, uncontrolled shaking, loss of speec_____
Yes	No	Numbness, sensory loss or nerve pain? _____
Yes	No	Frequent headaches? _____
Yes	No	Dizziness or fainting? _____

ENDOCRINE SYSTEM		
Yes	No	Diabetes? If yes, type I or type II? _____
Yes	No	Frequent urination or thirst? _____
Yes	No	Dry or burning mouth? _____ _____
Yes	No	Recent or unexplained gain/loss of weight? _____
Yes	No	Gland problem, goiter or thyroid condition? _____

GASTROINTESTINAL SYSTEM		
Yes	No	Liver disease? If yes, explain _____
Yes	No	Hepatitis? If yes, what type and when? _____
Yes	No	Frequent indigestion, diarrhea or vomiting? _____
Yes	No	History of gastroesophageal reflex disease (GERD)? _____

Patient Name: _____

GASTROINTESTINAL SYSTEM *continued*		
Yes	No	Alcohol use? If yes, how often and how much? _____

BLOOD/LYMPH SYSTEM		
Yes	No	Blood diseases or cancer? _____
Yes	No	AIDS, ARC, HIV+? If yes, age of diagnosis? _ _____
Yes	No	Anemia? _____
Yes	No	Abnormal or easy bruising? _____
Yes	No	Excessive bleeding following a scratch, cut or tooth extraction? _____
Yes	No	Persistently swollen or enlarged lymph nodes or glands? _____
Yes	No	Frequent nose bleeds? _____
Yes	No	Take anticoagulants (blood thinners, including aspirin? _____

GENITOURINARY SYSTEM		
Yes	No	Currently pregnant or possibly pregnant? _____
Yes	No	Any sexually transmitted diseases (including HPV)? _____
Yes	No	Kidney disease, transplant, infections or problems? _____
Yes**	No	Kidney dialysis? If yes, when? _____

MUSCULOSKELETAL SYSTEM		
Yes**	No	Joint replacement? If yes, which joint(s)? When? _____
Yes	No	Osteoarthritis or rheumatoid arthritis? If yes, indicate which type? _____
Yes**	No	Osteoporosis? If yes, are you taking any medications? Describe _____
Yes	No	Frequent bone fracture? _____
Yes	No	Back and/or neck injuries? _____
Yes**	No	Condition requiring corticosteroid therapy? _____
Yes	No	Muscle weakness? _____
Yes	No	Muscular dystrophy? _____

OTHER		
Yes	No	Major operations or hospitalization? If yes, explain _____
Yes	No	A reaction to any prescribed drugs or over-the-counter medications/drugs? If yes, indicate the medication/drug and please describe the reaction _____
Yes**	No	A reaction or allergy to anesthetics including dental anesthetics? If yes, describe _____
Yes**	No	A reaction or allergy to latex? If yes, describe _____
Yes**	No	A reaction to pine sap or pine nuts? If yes, describe _____
Yes	No	A sensitivity or allergy to specific foods? If yes, describe _____
Yes**	No	Chemotherapy or radiation therapy? If yes, which type and when? _____

Patient Name: _____

OTHER *continued*		
Yes**	**No**	**A methicillin- resistant staphylococcus aureus (MRSA) infection? If yes, when? _____**
Yes	**No**	**Do you use recreational drugs (including marijuana)? If yes, what type and when was the last time the drug(s) were used?**
		_____
Yes	**No**	**Do you use medicinal marijuana? If yes, for what condition, how often and last time used? _____**
		_____
Yes	**No**	**Skin rash, hives or skin problems? If yes, explain _____**
Yes	**No**	**Cold sores or mouth sores? _____**
Yes	**No**	**Facial injuries? If yes, describe _____**
Yes	**No**	**Tooth aches? If yes, explain _____**
Yes	**No**	**Hearing problems? If yes, explain _____**
Yes	**No**	**Eye problems? If yes, explain _____ _____**
Yes	**No**	**Are you on a restricted diet? If yes, indicate restrictions _____**
Yes	**No**	**Is there any other information regarding your overall health that we should know? If yes, please describe**
		_____
		_____

I ***certify*** that I have ***read and understand*** the above, and ***acknowledge*** that my questions, if any, regarding the inquires set forth above have been answered to my satisfaction. I will not hold ***the dentist,*** or ***dental hygienist*** or any member of the ***staff*** responsible for any errors or omissions that I may have made in completion of this form.

_____ _____

Patient Signature **Date**

_____ _____

Student Signature **Date**

_____ _____

Faculty Signature **Date**