VERMONT TECH DEPARTMENT OF DENTAL HYGIENE	MEDICAL/DENTAL HISTORY

Date:	Name:	DOB:

Email:

Address:			
Street or PO Box	*Town/City*	*State*	*Zip Code*

Telephone:	Home:	Cell:	Work:	Gender:

In Case of an Emergency, Please Contact:

Name:	Relationship:	Contact number:

Medicaid (Not Medicare) Insurance Information (if applicable)	Medicaid ID Number:

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 prescribed or over-the-counter medications or supplements? ☐ **Yes** ☐ **No**

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

Have you been fully vaccinated against Covid-19? ☐ **Yes** ☐ **No** **Have you received a Covid-19 booster?** ☐ **Yes** ☐ **No**

Do you have a history of exposure to large doses of radiation (including CT, PET or PET-CT scans and radiation therapy)? ☐ **No** ☐ **No**

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

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** ☐ **Power (Electric)**

Frequency of Brushing: **Frequency of flossing:** **Use of other dental devices:** ☐ **Yes** ☐ **No**

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

o You Have or Have You Ever Had Any of The Following? (Highlight yes or no and provide an explanation if appropriate)

*A response of yes to any of the questions marked with ** may require consultation and documentation from a physician prior to treatment.*

		ORAL CAVITY
Y	N	Orthodontic treatment? If yes, when?
Y	N	Clenching or grinding? If yes, do you wear a night guard or splint?
Y	N	Complications from extractions?
Y	N	Tooth sensitivity to hot, cold or sweets? If yes, describe:
Y	N	Bleeding gums? If yes, how long?
Y	N	Periodontal treatment? If yes, when?
Y	N	Halitosis (bad breath)?
Y	N	Pain or sounds around ears or any TMJ dysfunction? If yes, describe:
Y	N	History of oral cancer? If yes, when and location?
Y	N	History of HPV?
Y	N	History of HPV Vaccine?
Y	N	Lumps or swelling in the mouth? If yes, where?
Y	N	A lump in the throat or feeling that something is stuck in the throat?
Y	N	Continued swollen glands or lumps in the head and neck area despite antibiotic therapy?

		CARDIOVASCULAR SYSTEM
Y**	N	History of infective endocarditis (sub-acute bacterial endocarditis)?
Y**	N	Congenital heart disease? If yes, describe:
Y**	N	Any valvular defects and/or an artificial heart valve?
Y	N	Irregular heartbeat or arrhythmia?
Y	N	Myocardial infarction (heart attack)? If yes, when?
Y	N	Congestive heart disease?
Y	N	Cerebrovascular accident (stroke)? If yes, please describe any existing problems:
Y	N	Angina?
Y	N	High cholesterol?
Y	N	High or low blood pressure? If yes, high, or low?
Y	N	Cardiac by-pass surgery? If yes, when?
Y	N	Cardiac stents? If yes, when?
Y**	N	Heart transplant? If yes, when?
Y**	N	Implanted pacemaker? If yes, what brand and when?
Y	N	Implanted defibrillator? If yes, when?

		RESPIRATORY SYSTEM
Y	N	Lung disease: lung cancer emphysema, bronchitis, cystic fibrosis, COPD? If yes, explain:
Y	N	Asthma? If yes, how often and do you use an inhaler?
Y	N	Sleep apnea? If yes, describe treatment if applicable:
Y	N	Hay fever and/or environmental allergies? If yes, describe:
Y	N	Sinus problems? If yes, how often?
Y	N	Tuberculosis? If yes, indicate age:
Y	N	Chronic cough, hoarseness, sore throat, or cough that produces blood? If yes, describe:
Y	N	Nicotine/Tobacco habit (any form of tobacco, marijuana, or vaping)? If yes, how long, how much, how often?

		CENTRAL NERVOUS SYSTEM
Y	N	Multiple Sclerosis?
Y	N	Parkinson’s disease?
Y	N	Seizure disorder or convulsions? If yes, how often?
Y	N	Trembles, uncontrolled shaking, loss of speech?
Y	N	Numbness, sensory loss or nerve pain? If yes, where?
Y	N	Frequent headaches? If yes, describe frequency and possible triggers:
Y	N	Dizziness or fainting? If yes, describe frequency and possible triggers:

ENDOCRINE SYSTEM		
Y	N	Diabetes? If yes, type I, type II, or type III?
Y	N	Frequent urination or thirst?
Y	N	Dry or burning mouth?
Y	N	Recent or unexplained gain/loss of weight?
Y	N	Gland problem, goiter, or thyroid condition?

GASTROINSTESTINAL SYSTEM		
Y	N	Liver disease? If yes, explain:
Y	N	Hepatitis? If yes, what type and when?
Y	N	Frequent indigestion, diarrhea or vomiting? If yes, how often?
Y	N	History of gastroesophageal reflex disease (GERD)?
Y	N	Alcohol use? If yes, how often and how much?

BLOOD/LYMPH SYSTEM		
Y**	N	Current or past history of blood diseases or blood cancer? If yes, describe:
Y**	N	HIV+, AIDS, ARC? If yes, age of diagnosis?
Y	N	Anemia? If yes, type?
Y	N	Abnormal or easy bruising? If yes, explain:
Y	N	Excessive bleeding following a scratch, cut, nosebleed, or tooth extraction? If yes, describe:
Y	N	Persistently swollen or enlarged lymph nodes or glands?
Y	N	Taking anticoagulants (blood thinners, including aspirin)? If yes, for what condition?

GENITOURINARY SYSTEM		
Y	N	Currently pregnant or possibly pregnant? If yes, how many weeks?
Y	N	Any sexually transmitted diseases (including HPV)? If yes, explain:
Y	N	Kidney disease, transplant, infections or problems? If yes, explain:
Y**	N	Kidney dialysis? If yes, explain:

MUSCULOSKELETAL SYSTEM		
Y**	N	Joint replacement? If yes, which joint(s)? When? Name of orthopedist?
Y	N	Osteoarthritis or rheumatoid arthritis? If yes, indicate which type?
Y**	N	Osteoporosis? If yes, are you taking any medications? Describe:
Y	N	Frequent bone fracture? If yes, describe:
Y	N	Back and/or neck injuries? If yes, describe:
Y**	N	Any condition requiring corticosteroid therapy? If yes, explain:
Y	N	Muscle weakness? If yes, describe:
Y	N	Muscular dystrophy?

OTHER		
Y	N	Major operations or hospitalization? If yes, explain:
Y**	N	A reaction to any prescribed drugs or over-the-counter medications/drugs? If yes, indicate the medication/drug and please describe the reaction:
Y	N	History of Covid-19? If yes, date:
Y**	N	A reaction or allergy to anesthetics including dental anesthetics? If yes, describe:
Y**	N	A reaction or allergy to latex? If yes, describe:
Y**	N	A reaction to pine sap or pine nuts? If yes, describe:
Y	N	A sensitivity or allergy to specific foods? If yes, describe:
Y	N	Chemotherapy? If yes, when and for which type of cancer or disorder?
Y	N	Radiation therapy? If yes, when and for what type of disorder or disease?
Y**	N	A methicillin- resistant staphylococcus aureus (MRSA) infection? If yes, when?
Y	N	Any drug use? If yes, what type and when was the last time the drug(s) were used?
Y	N	Do you use medicinal marijuana? If yes, for what condition, how often and last time used?
Y	N	Cocaine use within the last 24 hours?
Y	N	Skin rash, hives, or skin problems? If yes, explain:
Y	N	Cold sores or mouth sores?
Y	N	Facial injuries? If yes, describe:
Y	N	Tooth aches? If yes, explain:

Y	N	Hearing problems? If yes, explain:
Y	N	Eye problems (other than need for glasses)? If yes, explain:
Y	N	Are you on a restricted diet? If yes, indicate restrictions:
Y	N	Is there any other information regarding your overall health that we should know? If yes, please describe:

Patient signature: **Date:**

Student signature: **Date:**

Faculty signature: **Date:**

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