Oregon TECH Dental Hygiene Program

PATIENT INFORMATION

Patient Name: ____ Today's Date ___________________

Date of Birth: _________ Age _______ Male ☐ Female ☐ Referred by: ____

Home Address: ________________________________ City_________________________ State: _____ Zip: __________

Phone: ______________________ (home); ______________________ (cell) Email ______________________________

Emergency Contact: ____ Emergency Contact Number: _________________

Person Responsible for Payment on Account: _______________________________ Relationship: __________________

Name of Physician: ________________________________ Date of Last Visit: _____________ Phone: _______________

Name of Dentist: __________________________________ Phone ______________Date of last visit/x-ray:___________

Dentist Address: __________________________________ City______________________ State: _____ Zip: __________

It is important that we know about your dental and medical history because many factors may have an influence on your dental health. Information you give is strictly confidential and will not be released to anyone without your permission.

DENTAL HEALTH HISTORY

Please respond to all questions. ***DO NOT write in the "Clinical Note" lines below.***

1.	How often do you brush?	________	
2.	Do you use a mechanical tooth brush?	YES	NO
3.	How often do you floss?	________	
4.	Do you use a mouth rinse?	YES	NO

A. DO YOU HAVE OR HAVE YOU EVER EXPERIENCED:

5.	Food catching between teeth	YES	NO
6.	Difficulty chewing	YES	NO
7.	Chewing on one side of your mouth	YES	NO
8.	Mouth breathing	YES	NO
9.	Dry mouth	YES	NO
10.	Gagging problems	YES	NO
11.	Dentures, partials or other removable appliances	YES	NO
12.	Canker sores	YES	NO
13.	Fever blisters (cold sores)	YES	NO
14.	Bleeding, swollen, or tender gums	YES	NO
15.	Slow-healing sores in or around your mouth	YES	NO
16.	Avoid brushing because of pain	YES	NO
17.	Sensitivity to fluoride	YES	NO
18.	Pain or sensitivity when teeth contact hot/cold/sour/sweet foods or liquids	YES	NO

Clinical Note (number and comment): ______________________________

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Clinical Note (number and comment) ______________________________

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B. DO YOU HAVE OR HAVE YOU EVER HAD:

19.	Orthodontics	YES	NO
20.	Oral/periodontal surgery	YES	NO
21.	Teeth whitening (bleaching)	YES	NO
22.	Jaw popping or clicking	YES	NO
23.	Clenching or grinding teeth	YES	NO
24.	Dental treatment requiring anesthetic (Novocain)	YES	NO
25.	Nail biting, chewing ice, pencils, etc.	YES	NO
26.	Thumb/finger sucking	YES	NO
27.	Tongue thrust	YES	NO
28.	Jaw related pain or TMD	YES	NO
29.	Frequent or severe headaches	YES	NO
30.	Dental treatment with nitrous oxide ("laughing gas")	YES	NO

Clinical Note (number and comment): ______________________________

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Clinical Note (number and comment) ______________________________

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31.	Have you had problems with previous dental treatment?	YES	NO
32.	Are you apprehensive about dental treatment?	YES	NO

Clinical Note (number and comment):

MEDICAL HISTORY

C. GENERAL HEALTH:

1. Is your general health good? (Yes) (No)

2. Has there been any change in your health within the last year? (Yes) (No)

If yes, what is the change? ______________________________

3. Are you being treated by a physician now? (Yes) (No)

If yes, for what? ______________________________

4. Have you been hospitalized or had a serious illness in the last three years? (Yes) (No)

If yes, why? ______________________________

5. Is antibiotic premedication required by your physician prior to dental treatment? (Yes) (No)

Clinical Note (# and comment): ______________________________

____

D. HAVE YOU EXPERIENCED:

6.	Chest pain/angina	YES	NO
7.	Swollen ankles	YES	NO
8.	Shortness of breath	YES	NO
9.	Fever, night sweats	YES	NO
10.	Persistent cough, coughing up blood	YES	NO
11.	Bleeding problems, bruising easily	YES	NO
12.	Sinus problems	YES	NO
13.	Difficulty swallowing	YES	NO
14.	Diarrhea, constipation, blood in stools	YES	NO
15.	Frequent vomiting, nausea	YES	NO
16.	Difficulty urinating, blood in urine	YES	NO

Clinical Note (number & comment):

17.	Dizziness	YES	NO
18.	Ringing in ears	YES	NO
19.	Headaches	YES	NO
20.	Fainting	YES	NO
21.	Blurred vision	YES	NO
22.	Seizures	YES	NO
23.	Excessive thirst	YES	NO
24.	Frequent urination	YES	NO
25.	Weight loss	YES	NO
26.	Jaundice	YES	NO
27.	Joint pain, stiffness	YES	NO

Clinical Note (number & comment):

E. DO YOU HAVE OR HAVE YOU EVER HAD:

28.	Heart disease	YES	NO
29.	Heart attack, heart defect	YES	NO
30.	Heart murmur	YES	NO
31.	Rheumatic fever	YES	NO
32.	Stroke	YES	NO
33.	High blood pressure	YES	NO
34.	Asthma, emphysema, bronchitis	YES	NO
35.	Tuberculosis	YES	NO
36.	Hepatitis, other liver disease	YES	NO
37.	Stomach problems, ulcers	YES	NO
38.	Allergies (drugs, food, latex, metals, etc.)	YES	NO
39.	HIV, AIDS	YES	NO

Clinical Note (number & comment):

40.	Herpes	YES	NO
41.	STD (syphilis, gonorrhea, etc.)	YES	NO
42.	Arthritis, rheumatism	YES	NO
43.	Eye disease	YES	NO
44.	Skin disease/condition	YES	NO
45.	Anemia	YES	NO
46.	Kidney, bladder disease	YES	NO
47.	Thyroid disorder, adrenal disorder	YES	NO
48.	Diabetes / Type: I II	YES	NO
49.	Tumors, cancer	YES	NO
50.	Family history of heart disease, cancer, diabetes	YES	NO

Clinical Note (number & comment):

F. DO YOU HAVE OR HAVE YOU EVER HAD:

51.	Prosthetic heart valve	YES	NO	**56.**	Surgeries	YES	NO
52.	Pacemaker	YES	NO	**57.**	Hospitalization	YES	NO
53.	Artificial joint	YES	NO	**58.**	Blood transfusions	YES	NO
54.	Radiation treatments	YES	NO	**59.**	Psychiatric care	YES	NO
55.	Chemotherapy	YES	NO	**60.**	Contact lenses/hearing aids	YES	NO

Clinical Note (number & comment):

G. DO YOU TAKE/USE:

61. Recreational drugs YES NO

If YES, please list:____________________

62. Alcohol YES NO

If YES, what kind, how much?____________________

63. Tobacco YES NO If YES, are you interested in quitting? YES NO

64. Cortisone, steroid YES NO

If YES, when/what dose/how long?____________________

65. Medicines/drugs/over-the-counter drugs (including herbs, supplements, vitamins, etc.) YES NO

Please list any medicines, drugs, herbs, supplements, etc. that you are currently taking:

H. WOMEN ONLY

66.	Are you using contraceptives?	YES	NO	**68.**	Are you nursing?	YES	NO
67.	Are you pregnant?	Yes	NO	**69.**	Have your reached menopause?	YES	NO

Clinical Note (number & comment):

I. ALL PATIENTS

70. Do you have or have you had any other disease or medical problems NOT listed above? YES NO

If, YES, please explain:____________________

Clinical Note (number & comment):

I understand that procedures undertaken by this learning institution take time. In order to give me the best possible care, I may be required to return for one or more visits. If I miss two confirmed appointments or are habitually late, I will be referred to my dentist or others to complete my care. _______________ (initial)

I recognize that not all dental/oral health procedures I may need can be provided at the Oregon Tech Dental Clinic. In that case, I will be referred to my dentist or others. ______________ (initial)

I recognize that the Oregon Tech Dental Clinic must continually accept new patients to provide students with a well-rounded learning experience. Therefore, the clinic may not be able to continue my care over several years. This policy will be explained as it may apply to me individually. ____________ (initial)

I certify that all information given on these forms is correct to the best of my knowledge. I consent to the performance of all procedures that are agreed to be necessary or advisable, and do hereby release the OIT Dental Hygiene Clinic from all responsibility for information I/we may not be aware of. ___________ (initial)

Yes ___ No ___ I authorize the release of my records to insurance companies and consulting health-care providers

Yes ___ No ___ I give permission for my child to have a fluoride treatment

Yes ___ No ___ I give permission for my child to have dental x-ray images or clinical photographs taken

Signature of Patient, Parent, or Guardian Signature of Student/Faculty Date

DATE	ADDITION or CHANGE	PATIENT SIGNATURE	STUDENT SIGNATURE	FACULTY SIGNATURE