OREGON TECH DENTAL HYGIENE CLINIC at CHEMEKETA
PATIENT INFORMATION Date:_______________

Last Name:___________________________________ First Name:____

Date of Birth:______________ Age:______ Male ☐ Female ☐ Referred by:__________________________________

Home address:_____________________________________ City:__________________ State:_____ Zip:____________

Home phone:_______________________ Cell:____________________ E-mail:____________________________________

Work phone:___________________________ Employer:____

Preferred Method of contact: ☐Home Phone ☐Work Phone ☐Cell Phone ☐Email ☐Text Message

Emergency contact: _________________________________ Emergency contact number: _____________________

Person Responsible for payment on account:________________________________ Relationship:______________

Name of medical doctor:________________________________ Date of last visit: _________ Phone______________

Name of dentist: _______________________________________ Date of last visit: _________ Phone_______________

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

What is the date of your last dental xrays?_____________

Are you apprehensive about dental treatment?---	Y	N
Have you had problems with previous dental treatment?---	Y	N

How often do you brush?___________________________

How often do you floss?___________________________

Do you use a mechanical/electric toothbrush?	Y	N
Have you ever had dental treatment requiring anesthetic?---	Y	N
Have you ever used nitrous oxide (laughing gas) during dental treatment?--------------------	Y	N

Do you now, or have you ever experienced any of the following?

Gagging problems------------------------------	Y	N
Food catching between teeth-----------------	Y	N
Difficulty chewing------------------------------	Y	N
Chewing on only one side of your mouth---	Y	N
Avoid brushing any part of your mouth because of pain--------------------------------	Y	N
Bleeding gums---------------------------------	Y	N
Swollen or tender gums---------------------	Y	N
Tooth sensitivity------------------------------	Y	N
Orthodontics-----------------------------------	Y	N
Have you had teeth whitening/bleaching	Y	N
Mouth breathing-------------------------------	Y	N
Fever blisters/Cold sores--------------------	Y	N
Canker sores-----------------------------------	Y	N
Nail biting---------------------------------------	Y	N
Thumb sucking--------------------------------	Y	N
Tongue thrust---------------------------------	Y	N
Dentures or removable dental appliances	Y	N
Have you ever noticed slow-healing sores in or around your mouth? --------------------------	Y	N

Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids --------------------------	Y	N
Cold foods or liquids -------------------------	Y	N
Sour food or liquids---------------------------	Y	N
Sweets ---	Y	N

Jaw problems

Does your jaw pop or click?------------------	Y	N
Do you clench or grind your teeth?---------	Y	N
Have you been diagnosed with TMJ or Temporomandibular disorder (TMD)-----	Y	N
Do you have jaw-related pain?-------------	Y	N
Frequent or severe headaches--------------	Y	N

Medical Health History

Do you have or have you had any of the following?

Heart Problems
- Stroke-- Y N
- Heart attack-- Y N
- Chest pain/angina------------------------------------- Y N
- Shortness of breath----------------------------------- Y N
- Swollen ankles-- Y N
- Blood Pressure problems-------------------------- Y N
- Heart murmur-- Y N
- Heart valve problem/ artificial heart valve---- Y N
- Taking heart medication-------------------------- Y N
- Rheumatic fever------------------------------------ Y N
- Pacemaker-- Y N
- **Artificial heart valve**---------------------------- Y N
- Heart surgery--------------------------------------- Y N

Blood/Cholesterol Problems
- Easy bruising-- Y N
- Frequent nosebleeds------------------------------ Y N
- Abnormal bleeding-------------------------------- Y N
- Anemia--- Y N
- Ever require a blood transfusion?-------------- Y N
- Hemophilia-- Y N
- Sickle cell disease---------------------------------- Y N
- High Cholesterol----------------------------------- Y N
- If you are taking blood thinners, what is your most current INR level?____________

Allergy Problems
- Hay fever--- Y N
- Sinus Problems------------------------------------- Y N
- Skin Rashes-- Y N
- Seasonal allergies---------------------------------- Y N

Intestinal problems
- Ulcers--- Y N
- Weight gain or loss--------------------------------- Y N
- Special diet-- Y N
- Kidney or bladder problems--------------------- Y N
- Acid reflux or GERD-------------------------------- Y N

Bone or joint problems
- Arthritis--- Y N
- Back or neck pain----------------------------------- Y N
- **Joint replacement (total hip, pins, implant etc.)**-- Y N
  - Date and type___________________________
- Rheumatism--- Y N

Are you taking or have you ever taken biphosphonates, or antiresorptive medications for osteoporosis, chemotherapy or cancer? (e.g., Fosamax, Actonel, Zometa, Boneva, Aredia) Y N

Thyroid Problems-------------------------------------- Y N

Premedication required by physician prior to dental treatment? Y N

Cancer/Tumor Y N
- Where/what kind?______________________________
- Chemotherapy-------------------------------------- Y N
- Radiation therapy---------------------------------- Y N

Diabetes Y N
- Type? _________________________________
- Urinate more than 6 times a day----------------- Y N
- Thirsty or dry mouth often----------------------- Y N
- Family history of diabetes------------------------ Y N
- What is your most current A1C level?__________

Respiratory problems
- Tuberculosis--- Y N
- Emphysema-- Y N
- Persistent cough------------------------------------ Y N
- Bronchitis-- Y N
- Asthma--- Y N

Do you drink alcohol? Y N
- How much/often?______________________________

Do you use tobacco? Y N
- What kind/how much?__________________________
- Are you interested quitting?---------------------- Y N

Do you use marijuana?---------------------------------- Y N

Do you use any recreational drugs---------------- Y N

History of drug or alcohol abuse ------------------- Y N

Hepatitis, jaundice, or liver trouble -------------- Y N
- Type of Hepatitis________________

Herpes-- Y N

Sexually Transmitted Disease (STD)------------------ Y N

HIV-positive/AIDS-- Y N

History of head injury?--------------------------------- Y N

Fainting spells or Seizures ----------------------------- Y N

Epilepsy or other neurological disease?------------- Y N

Eating disorder--- Y N

Nervousness/anxiety------------------------------------ Y N

Mental impairment/psychological disorder--------- Y N

Glaucoma--- Y N

Do you wear hearing aids or have difficulty with your hearing?-- Y N

Do you have any artificial prostheses, hip replacements, heart valves, other?
Type/Date:____

Do you have any other condition(s) not listed here? If yes, please describe:___________________________________
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During the past 12 months, have you taken any of the following?

Antibiotics or sulfa drugs----------------------------	Y	N
Anticoagulants (e.g., Coumadin)-------------------	Y	N
High blood pressure medicine----------------------	Y	N
Tranquilizers---	Y	N
Insulin, Orinase, or similar drug-------------------	Y	N
Aspirin--	Y	N
Digitalis or drugs for heart trouble----------------	Y	N
Nitroglycerin---	Y	N
Cortisone (Steroids)---------------------------------	Y	N
Natural remedies-------------------------------------	Y	N
Nonprescription drug/supplements--------------	Y	N

Please list any/all medicines or drugs you are currently taking (include herbs, supplements, vitamins, OTC drugs, etc.).

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Are you allergic to, or have you reacted adversely to any of the following?

Local anesthetics ("Novacaine")-------------------	Y	N
Penicillin or other antibiotics-----------------------	Y	N
Sulfa drugs--	Y	N
Barbiturates, sedatives, or sleeping pills?---------	Y	N
Aspirin, Acetaminophen, or Ibuprofen?-----------	Y	N
Codeine, Demerol, or other narcotics-------------	Y	N
Reaction to metals------------------------------------	Y	N
Latex or rubber dam---------------------------------	Y	N
Foods --	Y	N

Please specify__________________________

Women Only

Are you taking contraceptives or other hormones?--	Y	N
Are you pregnant?------------------------------------	Y	N
If so, expected delivery date______________		
Are you nursing?--------------------------------------	Y	N
Have you reached menopause?---------------------	Y	N

If so, do you have any symptoms?____________________________

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.

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.

YES ___ NO ___ **I authorize release of my records to consulting physicians/dentists.**

YES ___ NO ___ **I give permission for my child to have a fluoride treatment**

YES___ NO ___ **I give permission for my child to have radiographs and or clinical photographs taken**

____________________________________ ____________________________________

Signature of Patient, Parent, or Guardian **Student Signature/Faculty Initial**

Medical History/Physical Evaluation Update for Student and Faculty only

Date	Addition/Change	Signatures