

DENTAL, RADIOGRAPH AND HEALTH HISTORY

EagleSoft Number:

PATIENT: Please respond to the following questions. This information will be reviewed by the dental hygiene student and transferred to your permanent EagleSoft medical/dental history record.

Idaho State

UNIVERSITY

DEPARTMENT OF DENTAL HYGIENE

The privacy of your protected health information is important to us. This form will be shredded once it has been entered in to your EagleSoft medical/dental history record. A full disclosure of our Notice of Privacy Practices will be provided to you by the dental hygiene student in charge of your care. It describes how your health information will be handled by us in various situations deemed necessary to complete your dental care. We ask that you sign an electronic copy of this form to confirm you received our Notice of Privacy Practices.

DENTAL AND RADIOGRAPHIC HISTORY

DENTAL HISTORY

1. Have been to a dentist in the last year? YES NO
Date of last dental visit: _____
Reason for visit: _____
2. Are you unsatisfied with the appearance of your teeth? YES NO
3. Would it bother you to lose your teeth? YES NO
4. Do you experience any of the following:
 - Pain or discomfort.
 - Feeling nervous about dental treatment.
 - Loosening of your teeth.
 - Pain, swelling, or bleeding of your gums.
 - Food becoming caught between your teeth.
 - Other concerns.
 - NONE.
5. Check any of the following items that apply to you (past or present):
 - Teeth extracted.
 - Periodontal (gum) treatment/surgery.
 - Orthodontic treatment.
 - Oral surgery.
 - Mouthguard, retainer, partial or denture.
 - NONE.
 - Pain/Discomfort of the jaw (joint, ear, side of face).
 - Clicking or popping of jaw.
 - Difficulty opening/closing of jaw.
 - Difficulty chewing.
6. Do you have any of the following habits:
 - Clenching/grinding your teeth.
 - Holding foreign objects with your teeth.
 - NONE.
 - Mouthbreathing.
 - Biting your lips/cheek regularly.

DENTAL HISTORY COMMENTS:

For all positive responses, please add additional information:

RADIOGRAPHIC HISTORY

1. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? YES NO

2. Have you had dental x-rays in the past five years? YES NO

If YES, please provide the approximate dates and number of films taken: _____

3. Have you had medical x-rays in the past five years? YES NO

If YES, please provide the approximate dates and number of films taken: _____

WOMEN ONLY

1. Are you pregnant? YES NO

If YES, expected delivery date: _____

2. Are you nursing? YES NO

3. Are you currently on a hormonal contraceptive? YES NO

MEDICAL HISTORY

1. How do you rate your general health? GOOD FAIR POOR

2. Are you currently under the care of a physician? YES NO

3. Have you ever been hospitalized, had surgery or endured a serious illness? YES NO

4. Have you lost/gained more than 10 pounds in the past year? YES NO

Please record your weight: _____ lbs. ****Used to determine dosage of local anesthesia if administered****

5. Health screening (check all that apply):

- Shortness of breath.
- Limitations of physical activity.
- Wearing of contact lens.
- Frequently thirsty.
- Mouth is frequently dry.
- Pain in your chest when walking/climbing.
- Skin reaction to adhesive tape, band-aids, or kitchen gloves. (redness, rash, hives or itching).
- Medically recommended diet.
- Urinate more than 6 times a day.
- Swelling of lips, tongue or skin after dental treatment.

6. Check any of the following items that apply to you (past or present):

- Cardiac arrhythmia.
- Congenital Heart Disease.
- Heart disease/Attack/Angina.
- Heart surgery/Pace maker.
- Rheumatic fever/Heart Disease.
- Other Heart-related conditions.
- Artificial heart valve.
- Congestive heart failure.
- Heart Murmur/Mitral Valve Prolapse.
- High blood pressure.
- Stroke (CVA).
- Infective endocarditis.

7. _____ *AND/OR* _____

- Diabetes.
- Thyroid disease.
- Kidney/Liver disease/Hepatitis.
- HIV/AIDS.
- Bisphosphonates (Zomets, Aredia, Boniva etc.).
- Leukemia.
- Anemia/Sickle Cell Disease.
- Cancer/Chemotherapy/Radiation.
- Abnormal bleeding/ Blood disorder/ Hemophilia.

8. _____ *AND/OR* _____

- Allergies/Rash/Hives/Hay fever.
- Rheumatoid Arthritis.
- Spine/Back issues.
- Cold Sores/Fever blisters/Herpes.
- COPD/Emphysema/Chronic Bronchitis.
- Fainting/Dizzy spells.
- Full joint replacement.
- Psychiatric care.
- Persistent cough.
- Human Papilloma Virus (HPV).
- Tobacco use.
- Ulcerative colitis/Stomach ulcers.
- Osteoarthritis.
- Asthma.
- Chemical dependency/IV Drug use.
- Eating disorder.
- Epilepsy/Seizures.
- Hearing/Vision loss.
- Lupus erythematosus.
- Osteoporosis.
- Sexually Transmitted Diseases (STD).
- Sjogren's syndrome.
- Tuberculosis (past or present).

9. Do you have any conditions, disease, or problem not previously listed?
 YES NO

If YES, please specify: _____

10. Check any of the following items that you are allergic or have adverse reactions to:

- | | |
|---|--|
| <input type="radio"/> Local Anesthetics. | <input type="radio"/> Penicillin/Other antibiotics. |
| <input type="radio"/> Aspirin/Other pain relievers. | <input type="radio"/> Nitrous Oxide-Oxygen (laughing gas). |
| <input type="radio"/> Codeine/Narcotics. | <input type="radio"/> Food allergies. |
| <input type="radio"/> Latex. | <input type="radio"/> Non latex products (Thiurams, etc.). |

MEDICATIONS OVERVIEW FOR PRECAUTIONARY MEASURES

1. Check any of the following medications you are currently taking:

- | | |
|---|--|
| <input type="radio"/> Antibiotics/Sulfa drugs. | <input type="radio"/> Anticoagulants (blood thinners). |
| <input type="radio"/> Medications for high blood pressure. | <input type="radio"/> Digitalis/drugs for heart trouble. |
| <input type="radio"/> Antidepressants/Anti-anxiety. | <input type="radio"/> Tranquilizers. |
| <input type="radio"/> Aspirin/Pain relievers. | <input type="radio"/> Insulin/Tolbutamide. |
| <input type="radio"/> Antihistamines. | <input type="radio"/> Steroids (Cortisone). |
| <input type="radio"/> Anticonvulsants (Dilantin/Phenobarbital). | <input type="radio"/> Hormones (Birth Control or replacement). |
| <input type="radio"/> Vitamins/Supplements/Herbs. | |

List specific name of medications currently taking:

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Vitals:

BP: _____	TIDAL VOLUME: _____
PULSE: _____	MRD: _____
RESP: _____	WEIGHT: _____

Signatures:

Patient _____

Student _____

Faculty _____