MEDICAL ALERTS

Idaho State University
Department of Dental Hygiene

TREATMENT INFORMATION AND HEALTH HISTORY

Answers to the following questions are for our records. This information is confidential and will become part of your permanent dental hygiene record.

Please use pen to record information requested within this form.

PATIENT INFORMATION

❒Mr. ❒Mrs. ❒Ms. Name_____
(Last) (First) (MI)

Social Security Number _____ Sex ❒ M ❒ F

Date of Birth ____/____/____ Home Phone #(____)_____ Cell Phone # _____

Address _____
Street City, State Zip Code

ISU Student ❒ Yes ❒ No Student Bengal ID Number: _____

E-mail Address: _____

Referred to clinic by_____

Primary Physician's Name _____(Phone#)_____

Physician's Address _____
Street City, State Zip Code

Other Physician's Name _____(Phone#)_____

Physician's Address _____
Street City, State Zip Code

Dentist's Name _____(Phone#)_____

Dentist's Address _____
Street City, State Zip Code

Person to Notify in Case of an Emergency _____

Address _____
Street City, State Zip Code

Relationship _____ Day Phone Number (____)_____

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PERSON RESPONSIBLE FOR PAYING ACCOUNT (GUARANTOR)

❒ **Self** ❒ **Spouse** ❒**Guardian (***Relationship To Patient***)**_____

❒ Mr. ❒ Mrs. ❒ Ms. Name_____
(Last) (First) (MI)

Social Security Number _____ Sex ❒ M ❒ F

Date of Birth ____/____/____ Home Phone Number (_____)_____

Address _____
❒ Same as patient Street City, State Zip Code

ISU Student ❒ Yes ❒ No Student Bengal ID Number: _____

Employer's Name _____

Employer Phone Number._____ Ext. _____Group # _____

Insurance Name _____ Policy # _____

SPOUSE INFORMATION (OTHER GUARANTOR)

❒ Mr. ❒ Mrs. ❒Ms. Name_____
(Last) (First) (MI)

Social Security Number _____ Sex ❒ M ❒ F

Date of Birth ____/___/___ Home Phone Number (____)_____

Address _____
❒ Same as patient Street City, State Zip Code

ISU Student ❒ Yes ❒ No Student ID No. _____

Employer's Name _____

Employer Phone #_____ Ext. _____Group # _____

Insurance Name _____ Policy # _____

DENTAL INSURANCE INFORMATION

Please complete the following information if you have dental coverage

Subscriber's Name _____DOB _____

Subscriber's Address _____
Street City, State Zip Code

Employer's Name_____

Employer Phone # _____ Ext. _____ Group # _____

Insurance Name _____ Policy # _____

Address _____
P.O. Box/Street City, State Zip Code

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STATEMENT FOR PATIENTS

All ISU dental hygiene students and faculty are thoroughly educated to follow strict precautions designed to prevent the transmission of infectious disease such as Hepatitis (HBV or HCV) or Human Immunodeficiency Virus (HIV). For your protection, the Idaho State University Dental Hygiene Program follows recommendations set forth by the Occupational and Safety Health Administration (OSHA), the Center for Disease Control (CDC), the Organization for Safety, Asepsis and Prevention (OSAP), the American Dental Association (ADA), and the American Dental Hygienists' Association (ADHA). The probability of an accident involving transmission of blood from a patient to a clinician is very low.

If this should occur, however, it is our policy to recommend that the clinician and patient be tested for Hepatitis and/or HIV as soon as possible following the incident. The ISU Student Health Center, as well as other agencies such as Idaho County Health Departments, should provide the HIV counseling and testing. If you have any questions regarding this statement, please direct them to the dental hygiene receptionist. She will contact a faculty member who will speak with you directly.

READ CAREFULLY: REQUEST FOR TREATMENT AND RELEASE

The comprehensive dental hygiene care rendered at Idaho State University, Dental Hygiene Clinic will normally require more time to complete than what you may have previously experienced in a private dental office. Students are required to obtain a complete health history for each patient prior to initiating services. Such information is essential for performance of quality dental hygiene services and will be confidential. Please respond accurately to all information requested.

An assessment of your mouth and exposure of x-rays, if indicated, are necessary prior to recommending appropriate dental hygiene care for you. After this assessment your student dental hygienist will plan the dental hygiene care she/he feels is best for your current oral conditions and general health. Prior to presenting the information to you for your written consent, the assessment and plan for your dental hygiene care will be reviewed by a faculty member, who is a licensed dental hygienist. All care for you in this clinic is provided by a **dental hygiene student** under the supervision of a licensed dental hygienist and/or dentist. The services provided by the student clinician are required for his/her professional preparation to become a licensed Dental Hygienist.

I request treatment afforded through the Dental Hygiene Clinic of Idaho State University for myself and/or on behalf of my minor child or children. In consideration of affording treatment, I agree to hold harmless, release, and indemnify the State Board of Education and any and all agents, servants, and students of Idaho State University and employees including but not limited to, dentists, and dental hygiene faculty, from any and all causes of action, claims, demands, or liability which may arise out of such treatment on behalf of myself, my heirs, my executors, administrators or assigns; or on behalf of my minor child or children or his (their) heirs, executors, administrators or assigns.

I have read and understand the preceding paragraphs. This ***Request for Treatment and Release*** is hereby fully, freely, and voluntarily executed by me on:

Signature:

_____	_____	_____
Individual	Parent or Guardian (if under 18 years of age)	Date

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DENTAL AND RADIOGRAPHIC HISTORY

DENTAL HISTORY

1. Date of last visit to your dentist:_____

   Reason for visit:_____

2. Date of last oral prophylaxis (teeth cleaning), debridement and/or root planing:

   _____

3. Do you experience any of the following?
   - ❒ Pain or discomfort at this time?
   - ❒ 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**

4. Are you satisfied with the appearance of your teeth? ❒ Yes ❒ No

5. Would it bother you to lose your teeth? ❒ Yes ❒ No

6. Check any of the following that you <u>have had</u> or <u>have</u> at present.
   - ❒ Teeth extracted
   - ❒ Periodontal (gum) treatment/surgery
   - ❒ Orthodontic treatment
   - ❒ Oral Surgery
   - ❒ Mouthguard, retainer, partial, or denture
   - ❒ Pain/discomfort of the jaw (joint, ear, side of face)
   - ❒ Clicking or popping of the jaw
   - ❒ Difficulty in opening/closing your jaw
   - ❒ Difficulty in chewing
   - ❒ **None**

7. Do you <u>have</u> any of the following habits? <u>Please check all that apply</u>.
   - ❒ Clenching/grinding your teeth while awake or asleep
   - ❒ Holding foreign objects with your teeth
   - ❒ Biting your lips/cheeks regularly
   - ❒ Mouthbreathing
   - ❒ **None**

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 previous five years? ❒ Yes ❒ No

   If Yes, provide the approximate date and number of films taken:

   _____

3. Have you had medical x-rays in the previous five years? ❒ Yes ❒ No

   If Yes, please provide the approximate dates and number of films taken?

   _____

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MEDICAL HISTORY

1. How do you rate your general health? ❒ Good ❒ Fair ❒ Poor

   Date of last physical exam _____

2. Has there been any change in your general health within the past year? ❒ Yes ❒ No

3. Have you ever been hospitalized, or had a serious illness? ❒ Yes ❒ No

4. Have you lost or gained more than ten pounds in the past year? ❒ Yes ❒ No
   Please record your weight. _____lbs.
   (To determine dosage of local anesthesia/nitrous oxide if administered, or prescription medication.)

5. Health Screening - Check all that apply

   ❒ Shortness of breath?
   ❒ Pain in your chest w/walking or climbing?
   ❒ Limitations of physical activity?
   ❒ Skin reaction (redness, rash, hives or itching) to adhesive tape, bandaids, or kitchen gloves?
   ❒ Swelling of lips, tongue or skin after dental or medical treatment?
   ❒ Wearing contact lenses? ❒ Soft ❒ Hard
   ❒ Medically recommended diet?
   ❒ Frequently thirsty?
   ❒ Urinate more than six times a day?
   ❒ Mouth is frequently dry?
   ❒ **None**

6. Please check any of the following that you have had or have at present:

   ❒ Cardiac Arrhythmia
   ❒ Artificial Heart Valve
   ❒ Congenital Heart Disease (at birth)
   ❒ Congestive Heart Failure
   ❒ Heart Disease/Attack/Angina
   ❒ Heart Murmur/ Mitral Valve Prolapse
   ❒ Heart Surgery/Pacemaker
   ❒ High Blood Pressure
   ❒ Rheumatic Fever/Rheumatic Heart Disease
   ❒ Stroke
   ❒ Weight Control Drugs (Fen-phen, Redux, Pondimin, etc.)
   ❒ Other Heart-related Condition
   ❒ **None**

7. Please check any of the following that you have had or have at present:

   ❒ Diabetes
   ❒ Leukemia
   ❒ Thyroid Disease
   ❒ Anemia/ Sickle Cell Disease
   ❒ Kidney or Liver Disease/Hepatitis
   ❒ Cancer/Chemotherapy/Radiation Treatment
   ❒ HIV/AIDS
   ❒ Abnormal Bleeding/Blood Disorder/Hemophilia
   ❒ **None**

8. Please check any of the following that you have had or have at present:

   ❒ Allergies/Rash/Hives/Hay Fever
   ❒ Arthritis (Rheumatoid or Osteoarthritis)
   ❒ Asthma
   ❒ Back Problems
   ❒ Chemical Dependency/IV Drug Use
   ❒ Cold Sores/Fever Blisters/Herpes
   ❒ Eating Disorder
   ❒ Emphysema
   ❒ Epilepsy or Seizures
   ❒ Fainting or Dizzy Spells
   ❒ Hearing/Vision Loss
   ❒ Joint Replacement
   ❒ Lupus Erythematosus
   ❒ Mental Health Care
   ❒ Osteoporosis
   ❒ Persistent Cough/Chronic Bronchitis
   ❒ Sexually Transmitted Disease
   ❒ Sjögren's Syndrome
   ❒ Tobacco Use
   ❒ Tuberculosis
   ❒ Ulcerative Colitis/ Stomach Ulcers
   ❒ **None**

9. Do you have any condition, disease, or problem not previously listed? ❒ Yes ❒ No

If so, specify _____

10. Please check any of the following medications you are currently taking:

- ❒ Antibiotics/Sulfa Drugs
- ❒ Anticoagulants (Blood Thinners)
- ❒ Medicine for High Blood Pressure
- ❒ Digitalis/Drugs for Heart Trouble
- ❒ Antidepressants/Anti-anxiety drugs
- ❒ Tranquilizers
- ❒ Aspirin/Pain Relievers
- ❒ Insulin, Tolbutamide, Orinase/Similar Drug
- ❒ Antihistamine
- ❒ Cortisone (Steroids)
- ❒ Dilantin/Phenobarbital (Anticonvulsants)
- ❒ Hormones (Birth Control or Replacement Therapy)
- ❒ Vitamins, Supplements, and/or Herbs
- ❒ **None**

Other: Specify _____

11. Please check any of the following that you are allergic to or have adversely reacted to:

- ❒ Local Anesthetics
- ❒ Penicillin/Other Antibiotics
- ❒ Aspirin/Pain Relievers
- ❒ Nitrous Oxide-Oxygen Analgesia ("Laughing" Gas)
- ❒ Codeine/Other Narcotics
- ❒ Food Allergies (bananas, kiwis, potatoes, tomatoes, avocados, chestnuts, or other foods?)
- ❒ Latex
- ❒ **None**

Other: Specify _____

WOMEN ONLY:

12. Are you pregnant? Expected delivery date. _____ ❒ Yes ❒ No
13. Do you have any problems associated with your menstrual period? ❒ Yes ❒ No
14. Are you nursing? ❒ Yes ❒ No

To the best of my knowledge, all of the preceding answers are true and correct, and I have read and understand the "Statement for Patients" on page 3.

If I have any change in my health or if my medication(s) change, I will inform the student clinician at the next appointment.

_____ _____

Date of Signature Signature of Patient, Parent or Guardian

Department Use Only

MEDICAL HISTORY INITIAL EVALUATION AND UPDATES

	Date	BP	Resp.	Pulse	Patient Signature	Student Signature	Faculty Signature
1					N/A		

Additional Information: _____

Antibiotic Prophylaxis (reason, dosage, time)_____

	Date	BP	Resp.	Pulse	Patient Signature	Student Signature	Faculty Signature
Upda							

Updates:_____

Antibiotic Prophylaxis (reason, dosage, time)_____

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MEDICAL HISTORY EVALUATION UPDATES

	Date	BP	Resp.	Pulse	Patient Signature	Student Signature	Faculty Signature
Update 3							

Updates:_____

Antibiotic Prophylaxis (reason, dosage, time)_____

	Date	BP	Resp.	Pulse	Patient Signature	Student Signature	Faculty Signature
Update 4							

Updates:_____

Antibiotic Prophylaxis (reason, dosage, time)_____

	Date	BP	Resp.	Pulse	Patient Signature	Student Signature	Faculty Signature
Update 5							

Updates:_____

Antibiotic Prophylaxis (reason, dosage, time)_____

	Date	BP	Resp.	Pulse	Patient Signature	Student Signature	Faculty Signature
Update 6							

Updates:_____

Antibiotic Prophylaxis (reason, dosage, time)_____

	Date	BP	Resp.	Pulse	Patient Signature	Student Signature	Faculty Signature
Update 7							

Updates:_____

Antibiotic Prophylaxis (reason, dosage, time)_____

	Date	BP	Resp.	Pulse	Patient Signature	Student Signature	Faculty Signature
Update 8							

Updates:_____

Antibiotic Prophylaxis (reason, dosage, time)_____

Summary of Medications

CLIENT NAME:_____ **CLINICIAN:**_____ **DATE:**_____

1. _____ _____ _____ _____ _____
Brand Name Generic Name Dosage/Regimen Date Prescribed Prescribing Physician

Purpose(s)/Use: _____ Drug Class/Mechanism of Action _____

Reference and Page Number: _____ _____
Last Taken

Frequent Side Effects/ Adverse Reactions: Drug Interactions of Concern: Dental Considerations:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Update: Date: _____☐ No changes ☐ No longer taking ☐ Taking New Medication (***see new Medication Summary***)

Comments:

_____

2. _____ _____ _____ _____ _ _____
Brand Name Generic Name Dosage/Regimen Date Prescribed Prescribing Physician

Purpose(s)/Use: _____ Drug Class/Mechanism of Action _____

Reference and Page Number: _____ _____
Last Taken

Frequent Side Effects/ Adverse Reactions: Drug Interactions of Concern: Dental Considerations:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Update: Date: _____☐ No changes ☐ No longer taking ☐ Taking New Medication (***see new Medication Summary***)

Comments:

_____

3. _____ _____ _____ _____ _____
Brand Name Generic Name Dosage/Regimen Date Prescribed Prescribing Physician

Purpose(s)/Use: _____ Drug Class/Mechanism of Action _____

Reference and Page Number: _____ _____
Last Taken

Frequent Side Effects/ Adverse Reactions: Drug Interactions of Concern: Dental Considerations:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Update: Date: _____☐ No changes ☐ No longer taking ☐ Taking New Medication (***see new Medication Summary***)

Comments:

_____