301 Lawrence Place
Williston, Vermont
05495
USA
dhygiene@vtc.edu

Aug 21, 2020

PATIENT MEDICAL AND DENTAL HISTORY FORM

First name - Patient	Middle name	Last name - Patient	Patient birth date
test	-	test	Apr 30, 1959

Gender	Marital status
Male	Not specified

Email address
dentalhygiene@vtc.edu

Patient mailing address
Williston, VT, US
05495

Mobile #	Home #	Work #
-	-	-

Emergency contact	Emergency #	Relationship
-	-	-

Medicaid Number (if applicable)
-

MEDICAL PROVIDER

Primary Care Provider	Primary Care Provider Address	Primary Care Provider's Phone Number
-	-	-

Date of last visit	Reason for last visit
-	-

Are you currently under the care of physician (including any specialists)?
No selection

☐ If yes, please check box and provide an explanation below
-

Do you require an antibiotic prior to dental treatment (for a specific heart condition or artificial joints)?
No selection

Are you currently taking any over-the-counter or prescription medications?
No selection

☐ If yes, please check the box and list each medication and dosage below:
-

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

If yes, please provide the date, type and location of the radiation exposure.
-

DENTAL PROVIDER

Dentist's Name
-

Dentist's Address
-

Dentist's phone number
-

Date of last dental visit
-

Reason for last dental visit
-

Date of last dental radiographs (x-rays)
-

Type of last dental radiographs (x-rays)
No selection

ORAL HYGIENE HABITS

Toothbrush Texture
No selection

Type of Toothbrush
No selection

Frequency of brushing
No selection

If you answered other, please indicate how frequently you brush your teeth.
-

Frequency of flossing
No selection

Use of other dental devices
No selection

If yes, please list what you device(s) you use.
-

Do you have or have you ever had any of the following (check the box next to those that apply)? A positive response to any item marked with an ** may require consultation/documentation from a physician.

ORAL CAVITY

- ☐ Orthodontic treatment?
- ☐ Bleeding in the mouth or throat?
- ☐ Clenching or grinding your teeth?
- ☐ Lumps or swelling in the mouth?
- ☐ Complications from extractions?
- ☐ A lump in the throat or feeling that something is stuck in the throat?
- ☐ Tooth sensitivity to hot, cold or sweets?
- ☐ Hoarseness or a change in your voice?

- [ ] Bleeding gums?
- [ ] Have you had any periodontal (gum) treatment?
- [ ] Halitosis (bad breath)?
- [ ] Pain or sound around ears or any TMJ dysfunction?
- [ ] History of oral cancer?
- [ ] History of HPV?
- [ ] History of HPV vaccine?
- [ ] Continued swollen glands or lumps in the head and neck areas despite antibiotic therapy?
- [ ] Slurred speech or difficulty saying certain sounds?
- [ ] Tongue that tracks to one side when stuck out?
- [ ] Asymmetrical tonsils?
- [ ] Persistent or recurring throat infection that does not resolve with antibiotics?
- [ ] A persistent cough?
- [ ] Unilateral earache?

If you checked the box next to any of the questions in the "Oral Cavity" section, please provide more information if necessary:
-

CARDIOVASCULAR SYSTEM

- [ ] **History of infective endocarditis (subacute bacterial endocarditis)?
- [ ] **Congenital heart disease?
- [ ] **Artificial (prosthetic) heart valve(s)?
- [ ] History of a heart valve defect?
- [ ] Irregular heartbeat or cardiac arrhythmia?
- [ ] Myocardial infarction (heart attack)?
- [ ] Congestive heart disease?
- [ ] Cerebrovascular accident (stroke)?
- [ ] Angina?
- [ ] High blood pressure?
- [ ] Low blood pressure?
- [ ] Cardiac by-pass surgery?
- [ ] Cardiac stents?
- [ ] **Heart transplant?
- [ ] **Implanted pacemaker?
- [ ] Implanted defibrillator?
- [ ] High cholesterol?
- [ ] Swollen ankles?

If you checked the box next to any of the questions in the "Cardiovascular System" section, please provide more information if necessary:
-

RESPIRATORY SYSTEM

- [ ] **Lung cancer?
- [ ] Bronchitis?
- [ ] Emphysema?
- [ ] Chronic obstructive pulmonary disease (COPD)?
- [ ] Sleep apnea?
- [ ] Hay fever?
- [ ] Environmental allergies?
- [ ] Sinus problems?
- [ ] Tuberculosis?
- [ ] Chronic sore throat?
- [ ] Chronic hoarseness?
- [ ] Chronic cough?
- [ ] Cough that produces blood?
- [ ] Pneumonia?
- [ ] Cigarette Habit?
- [ ] E-Cigarette habit?
- [ ] Smokeless tobacco habit (chew, snuff, snus)?
- [ ] Marijuana habit?
- [ ] Family member with tuberculosis?

If you checked the box next to any of the questions in the "Respiratory System" section, please provide more information if necessary:

-

CENTRAL NERVOUS SYSTEM

- [ ] Multiple Sclerosis?
- [ ] Parkinson's Disease?
- [ ] Seizure disorder or convulsions?
- [ ] Problems associated with a stroke?
- [ ] Numbness or sensory loss?
- [ ] Nerve pain?
- [ ] Frequent headaches?
- [ ] Dizziness or fainting?
- [ ] Trembles, uncontrolled shaking, loss of speech?

If you checked the box next to any of the questions in the "Central Nervous System" section, please provide more information if necessary:

-

ENDOCRINE SYSTEM

- [ ] Type 1 diabetes?
- [ ] Recent or unexplained gain/loss of weight?
- [ ] Type 2 diabetes?
- [ ] Thyroid condition?
- [ ] Frequent urination or thirst?
- [ ] Other glandular disorder (ex: pancreatitis, adrenal gland disorders)?
- [ ] Dry or burning mouth?

If you checked the box next to any of the questions in the "Endocrine system" section, please provide more information if necessary:

-

GASTROINTESTINAL SYSTEM

- [ ] Liver disease?
- [ ] Frequent indigestion?
- [ ] Hepatitis A or E?
- [ ] Frequent diarrhea?
- [ ] Hepatitis B?
- [ ] Frequent vomiting?
- [ ] Hepatitis C?
- [ ] Gastroesophageal reflux disease (GERD)?
- [ ] Non-viral hepatitis?
- [ ] Alcoholism?

If you checked the box next to any of the questions in the "Gastrointestinal System" section please provide more information if necessary:

-

BLOOD/LYMPH SYSTEM

- [ ] **Current or past history of blood disease(s)?
- [ ] Excessive bleeding following a scratch, cut or tooth extraction?

- [ ] **Blood cancer?
- [ ] Abnormal or easy bruising?
- [ ] **HIV+, AIDS, ARC?
- [ ] Persistently swollen or enlarged lymph nodes or glands?
- [ ] Anemia?
- [ ] Frequent nose bleeds?
- [ ] Taking anticoagulants (blood thinners, including aspirin)?

If you checked the box next to any of the questions in the "Blood/Lymph System" section, please provide more information if necessary:
-

GENITOURINARY SYSTEM

- [ ] Currently pregnant or possibly pregnant?
- [ ] **Kidney dialysis?
- [ ] Any sexually transmitted diseases (including HPV)?
- [ ] **Kidney transplant?
- [ ] Kidney disease, infections or problems?

If you checked the box next to any of the questions in the "Genitourinary System" section, please provide more information if necessary:
-

MUSCULOSKELETAL SYSTEM

- [ ] **Joint replacement?
- [ ] Back and/or neck injuries?
- [ ] Osteoarthritis?
- [ ] **Any condition requiring corticosteroid therapy?
- [ ] Rheumatoid arthritis?
- [ ] Muscle weakness?
- [ ] **Osteoporosis?
- [ ] Muscular dystrophy?
- [ ] Frequent bone fractures?

If you checked the box next to any of the questions in the "Musculoskeletal System" section, please provide more information if necessary:
-

OTHER

- ☐ Major hospitalizations or operations?
- ☐ A reaction or allergy to any prescribed or over-the-counter medications/drugs?
- ☐ **A reaction or allergy to anesthetics including dental anesthetics?
- ☐ **A reaction or allergy to latex?
- ☐ **A reaction to pine sap or pine nuts?
- ☐ A sensitivity or allergy to specific foods?
- ☐ **A past or present history of cancer?
- ☐ **A history of/or currently receiving chemotherapy?
- ☐ **A history of/or currently receiving radiation therapy?
- ☐ A history of/or current methicillin-resistant staphylococcus aureus (MRSA) infection?
- ☐ Have used or currently use recreational drugs including marijuana?
- ☐ Have used or currently use medical marijuana?
- ☐ Skin rash, hives or skin problems?
- ☐ Cold sores or mouth sores?
- ☐ Facial injuries?
- ☐ Tooth aches?
- ☐ Hearing problems?
- ☐ Eye problems?
- ☐ Are you on a restricted diet?
- ☐ Cocaine use within the last 24 hours?

If you checked the box next to any of the questions in the "Other" section, please provide more information if necessary:

-

Is there any other information regarding your overall health that we should know? If yes, please describe:

-

VITAL SIGNS (For Instructor and Student Use ONLY)

Blood Pressure (indicate right or left arm):	Respiration Rate:	Pulse Rate:
-	-	-

Student signature and date:

-

Faculty signature and date:

-

PLEASE CHECK THE BOX "FINISH LATER" PRIOR TO EXITING. WE WILL COMPLETE THE FORM IN THE CLINIC FOLLOWING REVIEW WITH THE STUDENT AND FACULTY. YOU WILL SIGN THE FORM AT THAT TIME.

Signature

Test Test

Test Test

Form History

Signed	Aug 21, 2020 15:10:02 EDT	Signed by test test IP 155.42.237.2
Completed	Aug 21, 2020 15:10:02 EDT	The form has been completed