SIUC Dental Hygiene Clinic Health History
Southern Illinois University Carbondale

DATE________________

All information disclosed on this form is strictly confidential. The information is requested to better provide you with quality care.

Patient Name:____ **Gender: Male / Female**
Last First MI

Birth Date: ____________________ **Age** ______ **Email**_____________________________________

Phone: home ______________________________ **cell**_________________________________

Address: ____ **SIUC Student: Yes / No**
Street Address City State Zip

Ethnic Origin: **__American Indian or Alaska Native** **__Asian/Pacific Islander** **__Black (not Hispanic)**
__Hispanic/Latino **__White (not Hispanic)** **__Multi Ethnic_________________** **__Other_____________**

CIRCLE APPROPRIATE ANSWER

1. YES NO Is your general health good?
2. YES NO Has there been a change in your health within the last year?
3. YES NO Do you need to be pre-medicated prior to dental care? If Yes, what is your condition? ___________
4. YES NO Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? ____
5. YES NO Are you being treated by a physician now? For what? ______________________________
6. YES NO Do you have a disability? If so, please explain: __________________________________

IF YOU ANSWER YES TO ANY OF THE 4 ITEMS BELOW, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST

Have you had any of the following diseases or problems?

	Yes	No	Don't Know
Positive TB test?	________	________	________
Active Tuberculosis	________	________	________
Persistent cough greater than a 3 week duration	________	________	________
Cough that produces blood	________	________	________

HAVE YOU EXPERIENCED:

7. YES NO Chest pain
8. YES NO Swollen ankles
9. YES NO Shortness of breath
10. YES NO Recent weight loss
11. YES NO Sinus problems
12. YES NO Difficulty swallowing
13. YES NO Frequent vomiting or nausea
14. YES NO Dizziness or fainting spells
15. YES NO Blurred vision
16. YES NO Seizures and/or epilepsy
17. YES NO Frequent urination
18. YES NO Jaundice
19. YES NO Joint pain or stiffness
20. YES NO Headaches

DO YOU HAVE OR HAVE YOU HAD:

21. YES NO ADD/ADHD
22. YES NO Heart disease
23. YES NO Heart attack, heart defects
24. YES NO Heart murmur, mitral valve prolapse
25. YES NO Rheumatic fever
26. YES NO Stroke
27. YES NO High blood pressure
28. YES NO Asthma or emphysema
29. YES NO Bleeding disorder, anemia
30. YES NO Stomach problems or ulcers
31. YES NO Thyroid or adrenal disease
32. YES NO HIV/AIDS
33. YES NO Arthritis or rheumatism
34. YES NO Eye diseases
35. YES NO Skin disease
36. YES NO Herpes (oral)
37. YES NO Kidney or bladder disease
38. YES NO Allergy to penicillin or sulfa
39. YES NO Allergy to latex

40. YES NO Diabetes Type 1____ Type 2 _______
41. YES NO STD (syphilis, gonorrhea, genital herpes)
42. YES NO Tumor or cancer Type __________________
43. YES NO Autoimmune disease _______________________
44. YES NO Hepatitis (HBV, HCV, HAV)
45. YES NO Allergy to medications (list) ________________

DO YOU HAVE OR HAVE YOU HAD:

46. YES NO Psychiatric care
47. YES NO Radiation treatments or Chemotherapy
48. YES NO Prosthetic heart valve or pacemaker
49. YES NO Blood Transfusion
50. YES NO Artificial joint

51. YES NO Surgeries ____

ARE YOU TAKING / USING:

58. YES NO Recreational drugs. Please list them: ____________________

59. YES NO Drugs, medications, over- the- counter medicines (including Aspirin), alternative / herbal remedies: ________________
____

60. YES NO Do you **use** tobacco in any form?

If you smoke, what type? (check) How many? (number)
Cigarettes____ # per day____
Cigars/Cigarillos____ # per day____
Pipe____ #bowls per day____
Hookah____ # per week____
Marijuana____ #per day____

If you chew/snuff/pouch, what type? __________________ How much? __________________

How many days of the week do you use tobacco? 7 6 5 4 3 2 1

How soon after you wake up do you first use tobacco? Within 30 minutes_____ More than 30 minutes_____

How interested are you in stopping your use of tobacco? Not at all___ A little___ Somewhat___ Yes___ Very much___

If you decided to stop using tobacco completely during the next two weeks, **how confident are you** that you would succeed?
Not at all___ A little___ Somewhat___ Very confident___

Would you like help in reducing/quitting?
Now___ This month___ Later___ Not interested in quitting at this time___

61. YES NO Are you on any special diet or taking nutritional supplements? ____________________

62. YES NO Have you ever taken diet medications (Fen Phen / Redux)?

63. YES NO Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, please explain: ____________________
____

Family History of Disease: ____________________

WOMEN ONLY:

65. YES NO Are you pregnant or nursing?

66. YES NO Are you taking birth control pills / hormone replacement?

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dental hygiene student of any change in my health and /or medication.

Date: __________________ Patient Signature ____________________

Hygienist's Signature ____________________

Faculty Signature ____________________

RE-CARE REVIEW

Date: __________________ Patient Signature ____________________

Hygienist's Signature ____________________

Faculty Signature ____________________

Date: __________________ Patient Signature ____________________

Hygienist's Signature ____________________

Faculty Signature ____________________

DENTAL HISTORY

Patient name ____	Date:		Date:		Date:	
	YES	NO	YES	NO	YES	NO
1. What is the approximate date of your last dental examination?______________________						
a. Was all treatment completed? Y/N Have you been to SIUC Student Emergency Dental? Y/N						
b. Last date your teeth were cleaned:_______________ Are you currently receiving treatment from another dental professional? Y/N						
c. Date of last dental radiographs: ______________________ What type? ___________________________						
2. Are you having dental pain?						
3. Are your teeth frequently sensitive to hot, cold, or sweets?						
4. Are your gums frequently sore or tender?						
5. Do you have or have you had fever blisters, mouth ulcers, or sores in your mouth or on your lips? Y/N Do you have any sore areas in your mouth or on your face which are slow to heal? Y/N						
6. Do you have a bad taste or mouth odor?						
7. Do you think you have gum trouble (pyorrhea, trench mouth, etc.)?						
8. Do you have bleeding gums after brushing your teeth or bleeding from the mouth for no apparent reason (for example, do you notice blood on your pillow on arising)?						
9. Do you consistently breathe through your mouth awake or asleep?						
10. Do you frequently notice that your mouth or lips are dry?						
11. Do you have difficulty swallowing? Y/N Have you noticed any lumps, bumps, colored patches or other areas of concern in your head, neck or mouth? Y/N						
12. Does food become wedged between your teeth? Y/N Which teeth?						
13. Do you grind or clench your teeth?						
14. Have you worn braces for straightening your teeth? Y/N Have you ever had dental implants? Y/N						
15. Do you think teeth can affect your general health?						
a. Do you think your gums are having a harmful effect on your general health at this time?						
16. Did one or both of your parents lose all of their teeth?						
17. Would you be tremendously disturbed if you had to wear false teeth?						
18. Are you satisfied with the appearance of your teeth?						
19. In general, do dental treatments cause you much concern, worry or make you tense?						
20. Have you had any unusual difficulties associated with any previous dental treatment? If so, explain:______ ____________________________________ Have you had abnormal bleeding associated with previous extractions, surgery or trauma?						
21. Have you been instructed in home care of your teeth?						
22. Have you been instructed on Brushing ☐ Flossing ☐ Other Oral Hygiene Aids ☐ Proper diet ☐						
23. What kind of toothbrush do you use? Hard ☐ Medium ☐ Soft ☐ Brand Name____						
24. How often do you brush?_____ Floss?_____ Use other Aids?_____						
25. Have you had your teeth bleached?						
26. What type of oral care products do you use? Please list: ___________________________						
27. Have you ever been treated by a periodontist?						
28. Have you ever had any injuries involving your face, mouth, or teeth? Please explain: ______________________________________						
29. Have you had dental treatment using drugs other than local anesthetics, such as nitrous oxide or Valium?						
S = Student F = Faculty	S	F	S	F	S	F