HCC DENTALEDUCATION CLINIC MEDICAL/DENTAL QUESTIONNAIRE

PLEASE USE BLACK INK ONLY Chair #_____ **BP** _____/_____

Patient Name: _____

Age _____ Date _____

Your answers are for our records only and will be confidential except where disclosure is required by law.

Special Considerations:

MEDICAL QUESTIONS:

1.	Have there been any changes in your health in the past year?	Y	N
2.	Are you under the care of a physician?	Y	N
3.	Have you had any serious illnesses or operations?	Y	N
4.	Have you ever taken weight-loss medication?	Y	N
5.	Females: Are you pregnant?	Y	N

Explain any 'yes' answers:

_____

_____

6. Please check if you have (or have had) any of the following problems:

- ☐ AIDS / HIV Positive
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial heart valve(s)
- ☐ Artificial joint(s)
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemo/radiation therapy
- ☐ Circulation problems
- ☐ Cortisone treatments
- ☐ Cough, persistent or bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Headaches, frequent/severe
- ☐ Hearing loss
- ☐ Heart murmur
- ☐ Heart, any problems

Describe_____

_____

- ☐ Hemophilia
- ☐ Herpes
- ☐ Hepatitis A B C D
- ☐ High blood pressure
- ☐ Jaundice
- ☐ Jaw pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Respiratory disease
- ☐ Rheumatic fever
- ☐ Seizure disorders
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Skin rash
- ☐ Stroke
- ☐ Surgical implants
- ☐ Swelling, feet or ankles
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers/colitis/acid reflux
- ☐ Vision Impairment
- ☐ Other

Describe_____

_____

- ☐ **NONE OF THESE**

7. Allergies/Sensitivity:

- ☐ Anesthetic
- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Sulfa
- ☐ Iodine
- ☐ Latex
- ☐ Nickel
- ☐ Other _____
- ☐ **NONE OF THESE**

8. List any medications (prescription, non-prescription, and/or vitamins) you are currently taking:

_____

_____

_____

_____

9. Pre-medication required before dental treatment? Y N

Consulting Physician _____

Pharmacy _____

DENTAL QUESTIONS:

1. Date of your last:

   Visit to the dentist _____ Teeth cleaning _____ X-rays _____

Please circle the appropriate answer for each condition/disease.

2. Have you had any serious problem(s) with any previous dental treatment? Y N
3. Have you ever had an injury to your face, jaw, or teeth? Y N
4. Do you ever feel like you have a dry mouth? Y N
5. Have you ever had an unusual reaction to local anesthetic (numbing)? Y N
6. Do you wear full or partial dentures? Y N
7. Have you had any teeth replaced with a dental implant(s)? Y N
8. Have you had any teeth replaced with a fixed bridge(s)? Y N
9. Have you ever had any of the following treatment(s)?
   - ☐ Gum/periodontal treatment Y N
   - ☐ Orthodontics (braces) Y N
   - ☐ Endodontics (root canal) Y N
   - ☐ Extractions (teeth removed) Y N
   - ☐ Bleaching/whitening Y N
10. Do you have any piercings in the head and neck area? Y N

If yes, when were they done?_____ Where is/are the piercings?_____

Explain any yes answers:_____

_____

Check if you have any problems with the following:

☐ Bad breath	☐ Food trapped between teeth	☐ Sensitivity to cold
☐ Bleeding, sensitive gums	☐ Grinding or clenching teeth	☐ Sensitivity to hot
☐ Canker sore or cold sores	☐ Loose teeth	☐ Sensitivity to sweets
☐ Clicking or popping jaw: right or left	☐ Broken fillings	☐ Sensitivity to biting
	☐ Periodontal treatment	☐ Staining

11. Do you smoke or use tobacco in any form? Y N

    What kind? _____ How frequently? _____

    How long? _____ Would you like to quit? _____

ATTENTION: It is not our clinic policy to diagnose decay or dental disease. Procedures completed here do not replace regular checkups with your dentist. Please contact your dentist soon for a thorough examination.

The answers to the questions listed above are accurate. I understand this information will be used to determine the dental treatment I receive in this clinic and may be shared with other medical offices only as necessary. I will notify this clinic should any information change. I hereby authorize the HCC dental hygiene students to perform recommended services.

Signature of Patient, or parent if a minor: _____

Signature of Clinical Dentist: _____ Signature of Student: _____