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 you been to a dentist in the last year?  
   O YES  O NO
   Date of last dental visit: ________________________
   Reason for visit: ________________________________

2. Are you satisfied with the appearance of your teeth?  
   O YES  O NO

3. Would it bother you to lose your teeth  
   O YES  O NO

4. Do you experience any of the following?  
   O Pain or discomfort at this time  
   O Nervousness about dental treatment  
   O Loosening of your teeth  
   O Food becoming caught between your teeth  
   O Other Concerns  
   O None

5. Do any of the following apply to you (past or present)?  
   O Teeth Extracted  
   O Periodontal (gum) Treatment/Surgery  
   O Orthodontic Treatment  
   O Oral Surgery  
   O Mouthguard, Retainer, Partial or Denture  
   O Mouthbreathing  
   O Swelling (lips/tongue/skin) after tx  
   O Pain/Discomfort of the Jaw  
   O Clicking or Popping of Jaw  
   O Difficulty Opening/Closing of Jaw  
   O Difficulty in chewing  
   O Biting your Lips/Cheek Regularly  
   O None

6. Do you have any of the following habits?  
   O Clenching/Grinding  
   O Holding Foreign Objects with your Teeth  
   O None

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? O YES O NO

2. Have you had dental x-rays in the past five years? O YES O 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? O YES O NO
   If YES, please provide the approximate dates and number of films taken: ________________________________

WOMEN ONLY

1. Are you pregnant? O YES O NO
   If YES, expected delivery date: ________________________________

2. Are you nursing? O YES O NO

3. Are you currently on a hormonal contraceptive or hormone replacement therapy? O YES O NO

MEDICAL HISTORY

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

2. Has there been any change in your general health within the past year? O YES O NO

3. Are you currently under the care of a physician? O YES O NO
   Date of last physical ________________________________

4. Have you ever been hospitalized or had surgery for a serious illness/injury? O YES O NO

5. Have you lost or gained more than 10 pounds in the past year? O YES O NO
5. **Health screening** (check all that apply):

- O Shortness of Breath
- O Wearing of Contact Lenses
- O Frequently Thirst
- O Frequent Dry Mouth
- O Pain in your Chest with Walking or Climbing
- O Skin Reaction to Adhesive Tape Band-Aids
- O Medically Recommended Diet
- O Limitations of Physical Activity
- O Urinate more than 6 Times a Day
- O None

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

- O Cardiac Arrhythmia.
- O Congenital Heart Disease
- O Heart Disease/Attack/Angina.
- O Heart Surgery/Pace Maker/Defibrillator
- O Rheumatic Fever/Rheumatic
- O Other Heart Related Condition(s)
- O Artificial Heart Valve.
- O Congestive Heart Failure.
- O Heart Murmur/Mitral Valve Prolapse
- O High Blood Pressure
- O Stroke (CVA)
- O Infective Endocarditis
- O None

7. ——————————————————————————————————— AND/OR

- O Diabetes.
- O Thyroid disease.
- O Kidney disease/Dialysis
- O Liver Disease/Hepatitis
- O HIV/AIDS
- O Leukemia
- O Anemia/Sickle Cell Disease
- O Cancer/Chemotherapy/Radiation
- O Abnormal Bleeding or Disorder/Hemophilia
- O None

8. ——————————————————————————————————— AND/OR

- O Allergies/Rash/Hives/Hay fever.
- O Rheumatoid Arthritis.
- O Spine/Back issues.
- O Cold Sores/Fever blisters/Herpes.
- O COPD/Emphysema/Chronic Bronchitis.
- O Fainting or Dizzy spells
- O Full Joint Replacement.
- O Depression/Anxiety/Mental Illness.
- O Persistent cough.
- O Human Papilloma Virus (HPV)
- O Ulcerative Colitis/Stomach ulcers.
- O Osteoarthritis
- O Asthma
- O Chemical Dependency/IV Drug Use
- O Eating Disorder
- O Epilepsy/Seizure
- O Hearing /Vision Loss
- O Lupus Erythematosus
- O Osteoporosis
- O Sexually Transmitted Diseases
- O Sjogren's Syndrome
- O Tuberculosis
- O Tobacco Use
- O None
9. Do you have any conditions, disease, or problem not previously listed?

If YES, please specify: ____________________________  O YES  O NO

10. Please indicate allergy/adverse reaction to the following:

- O Local Anesthetics.
- O Aspirin/Other Pain Relievers
- O Codeine/Narcotics
- O Latex
- O Penicillin/Antibiotics
- O Nitrous Oxide-Oxygen (laughing gas)
- O Food Allergies
- O Non Latex Products (Thiurams, etc.)

MEDICAL HISTORY

For all positive responses please add additional information:

MEDICATION SUMMARY

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

- O Antibiotics/Sulfa Drugs
- O Antidepressants/Anti-anxiety
- O Aspirin/Pain Relievers
- O Antihistamines
- O Anticonvulsants (Dilantin/Phenobarbital)
- O Steroids (Cortisone)
- O Vitamins, Supplements, and/or Herbs
- O History of Bisphosphonate Use
- O Anticoagulants (blood thinners)
- O Heart Medications
- O Medication for High Blood Pressure
- O Tranquilizers
- O Insulin/Medication for Diabetes
- O Hormones (Thyroid, Birth Control, etc.)
- O Other
- O None

Medication Summary and Precautionary Measures

Please transfer pertinent medication information and precautionary measures from medication summary form for all medications currently being taken (name of medication, reason for taking, and precautionary measures)

Date:
HH (initial review, updates, etc.):
ASA Classification:
BP:
Pulse:
Resp:
Weight:
MRD:
Tidal Volume:

Signatures: ____________________________________________