## WESTERN KENTUCKY UNIVERSITY

**MEDICAL**

**ALERT**

## DENTAL HYGIENE CLINIC

**1906 COLLEGE HEIGHTS #11032**

**BOWLING GREEN, KY 42101**

**(270) 745-2426**

**PLEASE PRINT ALL INFORMATION**

NAME (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) \_\_\_ (Middle Initial)

TITLE Mr. Mrs. Miss Ms. Dr. HOME PHONE ( ) \_\_\_\_\_\_ WORK/CELL PHONE (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MALE FEMALE E-MAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED HEIGHT\_\_\_\_\_\_\_\_\_\_\_ WEIGHT\_\_\_\_\_\_\_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY STATE ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OCCUPATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AFFILIATED WITH WKU? YES (IF YES, HOW?) STUDENT FACULTY/ FAMILY STAFF/FAMILY OTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_

NO

HAVE YOU EVER BEEN A PATIENT IN THE WKU DENTAL HYGIENE CLINIC? YES NO

WHOM MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RACE/ ETHNIC ORIGIN

AMERICAN INDIAN (ALASKAN NATIVE) ASIAN PACIFIC ISLANDER BLACK (AFRICAN-AMERICAN)

HISPANIC/LATINO WHITE, NON-HISPANIC OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT PERSON \_\_\_\_\_\_\_\_\_ PHONE (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN’S** NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE ( )

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_

**DENTIST’S** NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE ( )

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_ZIP\_\_\_\_\_\_\_\_\_\_\_\_

**Payment for Services:** The dental hygiene clinic has no provision for billing patients. ***Payment must be made prior to the appointment.*** If paying by check, patient must bring proper identification at the time of appointment.

**Treatment Rendered:** “I understand that the WKU Dental Hygiene Clinic’s primary mission is the education of dental hygiene students and therefore it does not replace regular dental examination, diagnosis, and treatment by a private dental care provider. I understand that the educational learning environment progresses slower than private practice dental care and that my total care may involve more than one appointment and/or longer appointment times. I also understand that my treatment plan is developed following an accepted standard of care. Since deviation from the treatment plan may compromise the education of dental hygiene students, I will make every effort to comply with all aspects of the treatment plan. If I am unwilling to consent to the standard of care, I may be dismissed as a patient.”

|  |
| --- |
| Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of **Parent /Guardian**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **ANYONE UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY PARENT/LEGAL GUARDIAN** |

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| MEDICAL HISTORY | Yes No | Comments  (For Clinic Use Only) |
| 1. Has there been any change in your general health within the past year? |  |
| 1. Have you been under the care of a medical doctor during the past two years?   If yes, please explain: |  |
| 1. Have you had any serious illness or operation or been hospitalized in the past few years? If yes, describe the problem and any complications. |  |
| 1. Are you having pain or discomfort at this time? If yes, please explain: |  |
| 1. Are you now taking (or supposed to be taking) any medicine, drugs or pills of any kind (prescription and/or over the counter)? If yes, please list: |  |
| 1. Please check any of the following to which you are allergic to or to which you have reacted adversely:  |  |  | | --- | --- | | * Aspirin/aspirin-like products | * Local anesthetics | | * Barbiturates | * Metals | | * Codeine or other narcotics | * Penicillin or other antibiotics | | * Iodine | * Sedatives/sleeping pills | | * Latex | * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. Do you have any other allergies or have you been told not to take certain drugs, medicines or foods? If yes, please list: |  |
| 1. Have you ever had an adverse reaction to dental or general anesthetic? |  |
| 1. Do you have any medical condition(s) which require antibiotics prior to dental care?   If you answered yes above, have you taken this medication today? |  |
|  |
| 1. Have you had abnormal bleeding associated with previous dental treatment? |  |
| 1. Are you wearing contact lenses? |  |
| 1. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired? |  |
| 1. Do your ankles swell during the day? |  |
| 1. Do you use more than two pillows to prop yourself up in order to sleep? |  |
| 1. Have you unintentionally lost or gained more than 10 pounds in the past year? |  |
| 1. Do you ever wake up from sleep and feel short of breath? |  |
| 1. Are you on a special diet? |  |
| 1. Do you smoke, chew, use snuff, or use any other form of tobacco? |  |
| 1. Do you habitually consume alcoholic beverages? |  |
| 1. Do you habitually use controlled substances? |  |
| 1. Are you currently or have you in the past participated in a substance abuse program? |  |
|  |  |
| FOR WOMEN ONLY: | **Yes No** |
| Are you pregnant OR possibly pregnant? If yes, what month? Due Date? |  |
| Are you nursing? |  |
| Are you undergoing hormonal contraceptive treatment? (birth control pills, implants, shots) |  |
| Are you undergoing hormonal therapy? |  |

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please check the box for any condition that you have had or have at present.**

I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. If I ever have any changes in my health or change in my medications, I will inform the student hygienist at my next appointment.

Patient Signature Date

Parent or Responsible Party Relationship to Patient

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **ORTHOPEDIC** | | **GASTROINTESTINAL** | | **GENITOURINARY** | | **Comments**  **(For Clinic Use Only)** |
| Artificial (Prosthetic) Joint |  | Stomach/Intestinal Ulcers |  | Urinate Frequently |  |
| **CARDIOVASCULAR** | | Colitis |  | Kidney, Bladder Problems |  |
| Heart Transplant |  | Persistent Diarrhea |  | Dialysis |  |
| Congenital Heart Lesion/Defect |  | Hepatitis A (Infectious) |  | Kidney Transplant |  |
| Artificial (Prosthetic) Heart Valve |  | Hepatitis B (Serum) |  | Sexually Transmitted Diseases (STD/VD) |  |
| Prosthetic Implant |  | Hepatitis C |  | Syphilis |  |
| Indwelling Vein Catheter (Port) |  | Liver Disease |  | Gonorrhea |  |
| Infective endocarditis |  | Yellow Jaundice (Other Than at Birth) |  | Chlamydia |  |
| Heart Surgery |  | Cirrhosis |  | Genital Herpes |  |
| Coronary Bypass |  | Eating Disorder |  | HIV Positive |  |
| Angioplasty |  | Gastric Reflux |  | Multiple Sexual Partners |  |
| Congestive Heart Failure |  | Hiatal Hernia |  | **OTHER CONDITIONS** | |
| Heart Disease/Attack |  | **PULMONARY** | | Anxiety |  |
| Angina/Frequent Chest Pain |  | Hay Fever |  | Nervousness |  |
| High Blood Pressure |  | Sinus Trouble |  | Mental/Emotional Conditions |  |
| Heart Pacemaker or Defibrillator |  | Allergies or Hives |  | Unexplained Weight Loss |  |
| Aneurysm |  | Asthma |  | Frequent Sore Throats |  |
| **HEMATOLOGIC** | | Chronic Cough |  | Enlarged Lymph Nodes or Glands |  |
| Blood Transfusion |  | Emphysema |  | Tumor or Cancer |  |
| Anemia |  | Chronic Bronchitis |  | Radiation Therapy |  |
| Hemophilia |  | Tuberculosis (TB) |  | Chemotherapy |  |
| Leukemia |  | Breathing Difficulties |  |  |  |
| Sickle Cell Disease |  | **DERMAL/MUSCULOSKELETAL** | |  |  |
| Bleeding Disorder |  | Allergy to Latex (Rubber) |  |  |  |
| **NEUROLOGIC** | | Skin Rash/Hives |  |  |  |
| Physical Impairments |  | Herpes Simplex (Fever Blisters or Cold Sores) |  | **Disease/problem not listed**  **If yes, please list below** |  |
| Vision |  | Dark Mole (s) (Recent Change in Appearance) |  |  | |
| Hearing |  | Night Sweats |  |
| Speech |  | Osteoarthritis (Arthritis) |  |
| Glaucoma |  | Rheumatoid Arthritis |  |
| Earaches |  | Pain in Jaw Joints |  |
| Ringing in the Ears |  | Systemic Lupus |  |
| Severe Headaches |  | **ENDROCRINE** |  |
| Fainting or Dizzy Spells |  | Diabetes |  |
| Stroke (CVA) |  | Thyroid Disease |  |
| Epilepsy, Seizures, or Convulsions |  |  |  |
| Psychiatric Treatment |  |  |  |
| Panic Attacks |  |  |  |
| Phobias |  |  |  |
|  |  |  |  |
|  |  |  |  |

## 

## **Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DENTAL HISTORY**

***Comments***

**(Clinic Use Only)**

| **TREATMENT DATES** | | |
| --- | --- | --- |
| When was the date of your last dental visit? Date\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_  When was the date you last received dental hygiene treatment (teeth cleaned)? Date\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_  What was the date of your last dental radiographs was (x-rays)? Date\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ | | |
| **DENTAL HISTORY** | | **Yes or No** |
| Do you have regular dental exams? | |  |
| Are you currently having dental pain? | |  |
| Have you ever had any serious trouble associated with previous dental treatment?  If yes, please explain: | |  |
| Have you ever had any adverse effects associated with a dental injection?  If yes, please explain: | |  |
| Do dental treatments cause you much concern or worry or make you tense?  If yes, please check to what extent:  **slightly moderately extremely** | |  |
| Have you ever been diagnosed with oral cancer? | |  |
| Do you think your breath is offensive? | |  |
| Do you think your oral health is having a harmful effect on your general health at this time? | |  |
| Have you been instructed on the relationship between nutrition and oral health? | |  |
| Do you think your current nutritional habits are adversely affecting your oral health? | |  |
| What is the source of your drinking water? city well cistern other\_\_\_\_\_\_\_\_\_ | | |
| **PLEASE CHECK IF YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:** | | |
| * Oral appliances (Retainers) * Orthodontic treatment (Braces) * Periodontal treatment (Gum surgery) * Endodontic therapy (Root canals) * Removable full or partial denture (False teeth) * Oral surgery (Removal of teeth, jaw surgery) * Dental implants * Sealants * Occlusal (Bite) adjustment * Gums bleed when you brush or floss your teeth * Oral soft tissues (gums) frequently sore or tender * Unpleasant taste/bad breath * Discolored teeth * Dry mouth | * Burning tongue/lips * Frequent lip/mouth blisters * Swelling/lumps in mouth * Sore spots/irritation in mouth * Biting cheeks/lips * Clicking/popping jaws * Difficulty opening/closing jaws * Frequent sensitivity to hot/cold/sweets * Sensitivity to biting * Frequently have food wedge between teeth * Clenching/grinding of teeth * Change in bite * Mouth breathing * Tongue thrust | |
| **ORAL HYGIENE** | | **Yes or No** |
| Have you ever received oral hygiene instructions? | |  |
| Have you ever used disclosing tablets? | |  |
| What brand of toothpaste do you use? | | |
| **PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU USE TO CARE FOR YOUR TEETH AND GUMS.** | | |
| * Soft toothbrush * Hard toothbrush * Medium toothbrush * Powered toothbrush   Frequency of brushing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Floss * Floss holder * Floss threader | * Interdental brush * Oral Irrigator * Fluoride rinse/gel * Prescription mouthwash * Over-the-counter mouthwash * Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |