FERRIS STATE UNIVERSITY DENTAL HYGIENE PROGRAM HEALTH HISTORY FORM

If you have **Delta Dental** Insurance or are covered by **Medicaid** please present your card to the receptionist

NAME____ **E-Mail Address:**______________________________
LAST FIRST M.

I. PERSONAL INFORMATION

Mailing Address ____
Street City State Zip code

Date of Birth___________________ **Gender** M / F **Gender Pronoun(s)** ____________________

Cell phone ( ) ______________________ **Home phone** ( )________________ **Work phone** ( ) _______________

In case of emergency notify: ____
Name Relationship Phone number

If you are completing this form for another person, what is your relationship to that person?____________________________
Name Relationship

Circle the correct response/answer the following questions.

II. DENTAL INFORMATION

Y/ N Do your gums bleed when you brush?_______________
Y/N Do you have any dental implants in your mouth?
Y/N Are your teeth sensitive to cold, hot, sweets, pressure?
Y/N Do you have earaches or neck pains? ______________
Y/N Have you had any periodontal (gum) treatments?
Y/N Do you wear removable dental appliances?__________
Y/N Negative experiences in a dental office? _____________
Y/N Sores or ulcers in the mouth_____________________
Y/N Dry Mouth
Y/N Jaw pain

Do you have any dental concerns?______________________
____
Date of your last dental exam:________
What was done at that time?______________________
____
Date of last dental x-rays?____________
How do you feel about the appearance of your teeth?______
____

Name of Dentist:_________________________________
Name City State

III. MEDICAL INFORMATION

Have you had any of the following diseases or problems:
Y/N Active Tuberculosis
Y N Persistent cough greater than a 3-week duration
Y/N Cough that produces blood

If you have checked YES to any of the above questions, please stop and return this form to the receptionist.

Date of last physical examination_______________________
Name of Physician _____________________________
Name City State
____
Y/N Are you in good health__________________________
Y/N Are you currently seeing a physician? (non-routine care)
If **YES**, for what condition______________________
Y N Have you been hospitalized in the past 5 years?______
If **YES**, do you have medical clearance from your physician for dental treatment?____________________

Y/N Allergies: Please list ALL allergies
___________________ _______________________
___________________ _______________________

WOMEN ONLY

Y/N Are you or could you be pregnant?_______________
Y/N Nursing?___________________________________

Y/N Are you taking, or have you taken, any **diet drug**s such As Pondimin (fenfluramine), or Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?___

Y/N Do you drink alcoholic beverages?
Amount _______________

Y/N Do you use drugs or other substances for recreational purposes? If **YES**, please list ___________________
Frequency/Amount________________________________
Y/N Have you ever received treatment for drug/alcohol abuse
Y/N Are you currently receiving treatment for drug/alcohol abuse
What are you receiving treatment for? _____________

Y/N Do you use tobacco: smoke/ snuff/ chew /vape
Amount________ Frequency__________Length_______
If **YES**, how interested are you in stopping?
(circle one) Very / Somewhat / Not interested

Y/N Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
Type_________________ Date ___________________

Premedication:

Y/N Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?____
Please Explain:_______________________________________
____

MEDICAL INFORMATION CONTINUIED

Circle the correct response/answer the following questions.

Y/N AIDS or HIV infection___________________________

Y/N Hepatitis______________________________

Y/N Arthritis___________________________________

Y/N Asthma___________________________________

Y/N Bleeding Disorders___________________________

Y/N Bisphosphonate Therapy_______________________

Y/N Cancer/Chemotherapy/Radiation Treatment___________
Explain:

Y/N High Cholesterol

Y/N Cardiovascular disease. If **YES,** specify below:

- □ Angina Pectoris
- □ Angioplasty / Stent(ing)
- □ Arteriosclerosis
- □ Artificial heart valve
- □ Blood pressure ↑ or ↓
- □ Congenital heart defects
- □ Congestive heart failure
- □ Coronary artery disease (bypass, graft, etc.)
- □ Heart attack (MI)
- □ Heart murmur
- □ Pacemaker
- □ Rheumatic Fever/Mitral Valve Prolapse
- □ Stents
- □ Stroke

Y/N Chronic obstructive pulmonary disease (COPD)

Y N Diabetes. If YES, specify below:___________________
___Type I (insulin dependent) ___ Type II

Y/N Eating disorder. If YES, specify:____________________ Y/N
Y / N Epilepsy______________________________________
Y/N Fainting (syncope)_____________________________
Y/N Flu – Seasonal / H1N1___________________________
Y/N Gastrointestinal disease__________________________
Y/N Glands (persistent swollen on head and/or neck)_________
Y/N Migraines_____________________________________
Y/N Kidney problems________________________________
Y/N Mononucleosis, Infectious_________________________

Y/N Neurological/Mental Health disorders. If **YES**, specify:
____

Y/N Osteoporosis
If yes, please explain:_____________________________
____
____

Y/N Respiratory problems. If yes, specify:_______________
Y/N Sexually transmitted disease______________________

Y/N Sinus trouble___________________________________

Y/N Thyroid gland disorders___________________________

Do you have any disease, condition, or problem not listed above that you think we should know about? Please explain:

NOTE: The Dental Hygiene Clinic staff, student, and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. YOU WILL BE ASKED TO COMPLETE A NEW HEALTH HISTORY FORM **EVERY THREE YEARS** UNLESS THERE HAVE BEEN SIGNIFICANT CHANGES TO YOUR HEALTH OR AT THE CLINIC REQUEST.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold FSU Dental Hygiene, or any other member of the staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

____ ______________________________
Signature of Patient/Legal Guardian Date

Blood pressure__________ (to be recorded in the clinic)
Pulse _______________

Complete for subsequent visits only: I have read and updated my answers to the medical history questions listed above.

1)____________________ Initials / Date / BP/ Pulse
2)____________________ Initials / Date / BP/ Pulse
3)____________________ Initials / Date / BP/ Pulse
4)____________________ Initials / Date / BP/ Pulse
5)____________________ Initials / Date / BP/ Pulse
6)____________________ Initials / Date / BP/ Pulse
7)____________________ Initials / Date / BP
8)____________________ Initials / Date / BP/ Pulse
9)____________________ Initials / Date / BP/ Pulse
10)____________________ Initials / Date / BP/ Pulse
11)____________________ Initials / Date / BP
12)____________________ Initials / Date / BP/ Pulse