Texas Woman's University
Dental Hygiene Program

Date: _____

PATIENT INFORMATION

First name: _____ Last name: _____ Middle Initial: ___

Address: _____ City: _____ State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Occupation: _____

Email: _____ ☐ I would prefer to receive correspondences via email.

Employment Status: ☐ Full time ☐ Part Time ☐ Retired

Closest Relative or Friend: _____ Phone: _____

Primary Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Date & type of last dental X-rays: _____

MEDICAL HISTORY

Are you under a physician's care now?	☐ Yes	☐ No	Are you on a special diet?	☐ Yes	☐ No
Do you or have you taken Phen-Fen or Redux?	☐ Yes	☐ No	Do you use controlled substances?	☐ Yes	☐ No
Have you ever had a serious head or neck injury?	☐ Yes	☐ No	Women: Are you pregnant, trying to get pregnant, or nursing?	☐ Yes	☐ No

Do you have or have you had any of the following? Answer Yes or No, please **DO NOT** leave blank.

AIDS/HIV Positive	☐ Yes	☐ No	Depression/Bipolar	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Allergy/Anaphylaxis	☐ Yes	☐ No	Drug Addiction	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Eating Disorder	☐ Yes	☐ No	Low blood sugar	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Nervousness/Anxiety	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Excessive Bleeding	☐ Yes	☐ No	Osteoarthritis	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Fainting/Dizziness	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Artificial Joint	☐ Yes	☐ No	Head/ neck/back pain	☐ Yes	☐ No	Psychiatric Condition	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart Attack/Failure	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Autoimmune Disease	☐ Yes	☐ No	Heart Condition/Defect	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Heart Pace Maker	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Chest Pains/Angina	☐ Yes	☐ No	Human Papilloma Virus	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Cold Sore/Fever Blister	☐ Yes	☐ No	Gastrointestinal Issue	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No				Tuberculosis	☐ Yes	☐ No

- OVER –

MEDICATION QUESTIONNAIRE

Please list all medications that you take, including prescription, herbal, and over-the counter.

Medication	**Reason Taking**	*Office Use Only*

Are you allergic to any of the following?
☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other:
If yes, type of reaction:

Please describe any serious illness, injury, hospitalization, or surgery not listed that you think we should know about?

DENTAL QUESTIONNAIRE

Smoke or use smokeless tobacco	☐ Yes	☐ No	Brush at least once each day	☐ Yes	☐ No
Bite/chew lips or cheeks	☐ Yes	☐ No	Use fluoride toothpaste	☐ Yes	☐ No
Have dentures that fit poorly	☐ Yes	☐ No	Floss at least once each day	☐ Yes	☐ No
Have a history of oral cancer	☐ Yes	☐ No	Drink tap water that has fluoride	☐ Yes	☐ No
Have frequent dry mouth	☐ Yes	☐ No	Drink bottled water only	☐ Yes	☐ No
Clench or grind teeth	☐ Yes	☐ No	Have regular dental visits	☐ Yes	☐ No
Need to improve nutrient/vitamin intake	☐ Yes	☐ No	Have dental implants	☐ Yes	☐ No
Have a family history of gum disease	☐ Yes	☐ No	Have chronic TMJ (jaw) problems	☐ Yes	☐ No
Gums bleed when brushing or flossing	☐ Yes	☐ No	Have oral piercing(s)	☐ Yes	☐ No
Have more than 2 alcohol drinks per day	☐ Yes	☐ No			
Use alcohol-based mouth rinse (Listerine/Scope)	☐ Yes	☐ No	Are you nervous about having dental treatment?	☐ Yes	☐ No
Are you having oral pain or dental discomfort at this time?	☐ Yes	☐ No	Have you had a bad experience in the dental office?	☐ Yes	☐ No

When you play contact sports, do you use a mouth guard? ☐ Yes ☐ No ☐ Not applicable

When did you last have a dental exam? _____ Dental Work? _____ Teeth Cleaned? _____

What type of toothbrush do you use? Soft____Medium____Hard_____What toothpaste do you use?_____

What other hygiene aids do you use?

_____

What is the main reason for your visit today?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the TWU Dental Hygiene Clinic of any changes in medical status. If patients are under 18 years of age, we ask that parent/guardian stay on campus while treatment is rendered. Parent/Guardian must sign for patient's under 18 years of age.

Date	**Patient/Parent/Guardian Signature**	**DH Student**	**Instructor**