WESTERN KENTUCKY UNIVERSITY
DENTAL HYGIENE CLINIC
1906 COLLEGE HEIGHTS #11032
BOWLING GREEN, KY 42101
(270) 745-2426

MEDICAL ALERT

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?	☐	☐	
2. Have you been under the care of a medical doctor during the past two years? If yes, please explain:	☐	☐	
3. Have you had any serious illness or operation or been hospitalized in the past few years? If yes, describe the problem and any complications.	☐	☐	
4. Are you having pain or discomfort at this time? If yes, please explain:	☐	☐	
5. 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**:**	☐	☐	
6. 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_____			
7. Do you have any other allergies or have you been told not to take certain drugs, medicines or foods? If yes, please list:	☐	☐	
8. Have you ever had an adverse reaction to dental or general anesthetic?	☐	☐	
9. 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?**	☐	☐	
10. Have you had abnormal bleeding associated with previous dental treatment?	☐	☐	
11. Are you wearing contact lenses?	☐	☐	
12. 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?	☐	☐	
13. Do your ankles swell during the day?	☐	☐	
14. Do you use more than two pillows to prop yourself up in order to sleep?	☐	☐	
15. Have you unintentionally lost or gained more than 10 pounds in the past year?	☐	☐	
16. Do you ever wake up from sleep and feel short of breath?	☐	☐	
17. Are you on a special diet?	☐	☐	
18. Do you smoke, chew, use snuff, or use any other form of tobacco?	☐	☐	
19. Do you habitually consume alcoholic beverages?	☐	☐	
20. Do you habitually use controlled substances?	☐	☐	
21. 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.

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	☐					

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 _____

Patient Name _____ ***Date*** _____

DENTAL HISTORY

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_____/_____/_____

Comments
(Clinic Use Only)

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_____

I attest to the accuracy and completeness of the information I have provided. I give my permission to the WESTERN KENTUCKY UNIVERSITY Dental Hygiene Program to provide preventative oral health services, including radiography survey.

I authorize WESTERN KENTUCKY UNIVERSITY Dental Hygiene Program to disclose information from my medical/dental history to my physician or dentist for consultation/treatment purposes.

I authorize the WESTERN KENTUCKY UNIVERSITY Dental Hygiene Program to utilize these treatment records for educational purposes and to send of the treatment records, including radiographs, to the dentist named on this history.

I understand that if a student or faculty is inadvertently exposed to my blood or saliva I will be requested to undergo medical testing for the purpose of determining treatment needs of the exposed individual.

INITIAL APPOINTMENT

Date_____________________ Patient or Guardian Signature____

BP_________________ Pulse____________________ Respiration____________________ Temperature______________________

Clinician Sign: _____________________________________ Faculty Sign: ____

MEDICAL HISTORY UPDATE

Date___________ BP_____________ Pulse_______________ Respiration_______________ Temperature________________

Please note any changes in the patient's health since s/he last completed the medical/dental history and any medications the patient is taking: ____

____ Patient/ Guardian Sign: ____

Clinician Sign: ______________________________________ Faculty Sign: ____

Date___________ BP_____________ Pulse_______________ Respiration_______________ Temperature________________

Please note any changes in the patient's health since s/he last completed the medical/dental history and any medications the patient is taking: ____

____ Patient/ Guardian Sign: ____

Clinician Sign: ______________________________________ Faculty Sign: ____

Date___________ BP_____________ Pulse_______________ Respiration_______________ Temperature________________

Please note any changes in the patient's health since s/he last completed the medical/dental history and any medications the patient is taking: ____

____ Patient/ Guardian Sign: ____

Clinician Sign: ______________________________________ Faculty Sign: ____

Date___________ BP_____________ Pulse_______________ Respiration_______________ Temperature________________

Please note any changes in the patient's health since s/he last completed the medical/dental history and any medications the patient is taking: ____

____ Patient/ Guardian Sign: ____

Clinician Sign: ______________________________________ Faculty Sign: ____