SIU Southern Illinois University
CARBONDALE

Dental Hygiene Clinic

Patient Name: _____ _____ _____ _____
Last First Middle Preferred Name

Gender: ☐ Male ☐ Female ☐ Other Date of Birth (MM/DD/YY): _____

Address: _____
Street City State Zip Code

Phone Number: _____ Email Address: _____

**Do you have any of the following:**

Positive Tuberculosis (TB) test? ☐ Yes ☐ No
Active Tuberculosis (TB)? ☐ Yes ☐ No
Cough that produces blood? ☐ Yes ☐ No
Persistent cough? ☐ Yes ☐ No

Is your general health good? ☐ Yes ☐ No
Has there been a change in your health within the last year? ☐ Yes ☐ No
If yes, please explain. _____

_____

Are you being treated by a physician now? ☐ Yes ☐ No
If yes, please explain. _____

_____

Have you been hospitalized or have had a serious illness in the last three years? ☐ Yes ☐ No
If yes, please explain. _____

_____

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? ☐ Yes ☐ No

Are you taking any prescriptions or over-the-counter medications? ☐ Yes ☐ No
If yes, please list. _____

_____

Are you taking any vitamins, natural or herbal preparations, and/or dietary supplements? ☐ Yes ☐ No
If yes, please list. _____

_____

Are you currently being treated by a mental health professional? ☐ Yes ☐ No

**Joint Replacement**

Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)? ☐ Yes ☐ No
If yes, date? _____
If yes, were there any complications? ☐ Yes ☐ No
If yes, please explain. _____

Are you taking or scheduled to begin an antiresorptive agent (like Fosamax, Actonel, Atelvia, Boniva, Reclast, Prolia) for Osteoporosis or Paget's disease? ☐ Yes ☐ No

Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? ☐ Yes ☐ No

**Heart Conditions**

Artificial (prosthetic) heart valve? ☐ Yes ☐ No
Previous infective endocarditis? ☐ Yes ☐ No
Damaged valves in transplanted heart? ☐ Yes ☐ No
Congenital heart disease (CHD)? ☐ Yes ☐ No

a. Unrepaired, cyanotic heart disease (CHS)? ☐ Yes ☐ No
b. Repaired (completely) in the last 6 months? ☐ Yes ☐ No
c. Repaired CHD with residual defects? ☐ Yes ☐ No

Note: Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD

**Do you have or have you had:**

| | | |
|---|---|---|
| ☐ Acid Reflux | ☐ Congestive Heart Failure | ☐ Liver Disease |
| ☐ AIDS or HIV | ☐ Diabetes Type 1 | ☐ Low Blood Pressure |
| ☐ Angina | ☐ Diabetes Type 2 | ☐ Lupus Erythematosus |
| ☐ Arthritis | ☐ Eating Disorder | ☐ Neurological Disorder |
| ☐ Asthma | ☐ Emphysema | ☐ Osteoporosis |
| ☐ Autoimmune Disease | ☐ Epilepsy | ☐ Radiation Treatment |
| ☐ Bronchitis | ☐ Gastrointestinal Disorder | ☐ Rheumatic Fever |
| ☐ Bleeding Disorder | ☐ Heart Attack | ☐ Rheumatoid Arthritis |
| ☐ Cancer | ☐ Heart Murmur | ☐ Sleep Apnea |
| ☐ Cardiovascular Disease | ☐ Hepatitis | ☐ Stroke |
| ☐ Chronic Pain | ☐ High Blood Pressure | ☐ Thyroid Problems |
| ☐ Chemotherapy | ☐ Kidney Problems | ☐ Ulcers ☐ None of these |

Do you have any medical conditions not listed above? Please list.

_____

Do you use any of the following?

☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Controlled Substances ☐ Smokeless Tobacco ☐ Marijuana ☐ Vape

☐ None of these If yes: How much? _____ How often? _____

**Women only:** Are you pregnant? ☐ Yes ☐ No Number of weeks: _____ Nursing? ☐ Yes ☐ No

**Allergies**

Are you allergic to or have you had a reaction to:

☐ Sulfa drugs ☐ Penicillin ☐ Latex ☐ Gluten ☐ Peanuts ☐ None of these

☐ Other allergy; please list: _____

Please explain: _____

**Dental History**

Dental office name? _____

City/State? _____

Date of your last dental examination? _____

Last date your teeth were cleaned? _____
Did you receive X-rays? ☐ Yes ☐ No
Are you having dental pain? ☐ Yes ☐ No
If yes, please explain_____
Do your gums bleed when you brush or floss? ☐ Yes ☐ No
Is your mouth dry? ☐ Yes ☐ No
Are your teeth sensitive to: ☐ Cold ☐ Hot ☐ Sweets ☐ Pressure ☐ None of these
Have you had any periodontal (gum) treatment? ☐ Yes ☐ No
Have you ever had orthodontic treatment (braces)? ☐ Yes ☐ No
Do you grind or clench your teeth? ☐ Yes ☐ No
Did one or both of your parents lose all their teeth? ☐ Yes ☐ No
Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No
In general, do dental treatments cause you much concern, worry, or make you tense? ☐ Yes ☐ No
Have you had any unusual difficulties associated with any previous dental treatment? ☐ Yes ☐ No
If yes, please explain. _____

How many times per day do you brush? _____ How many times per day do you floss? _____

Do you have or had you had:

| | | |
|---|---|---|
| ☐ Earaches | ☐ Clicking or popping of the jaw | ☐ Injury to your head or mouth |
| ☐ Neck Pain | ☐ Sores or ulcers in your mouth | ☐ None of these |

I hereby certify that the above health history information is complete and accurate to the best of my knowledge. I understand that providing false or incomplete information may affect my care. I take full responsibility for the accuracy of the information provided.

Signature: _____ Relationship: _____ Date: _____