CONFIDENTIAL PATIENT INFORMATION AND MEDICAL/DENTAL QUESTIONNAIRE

Dental Hygiene/Attn: Clinic Receptionist
515 North Washington Square, Suite 107
Lansing, MI 48933

Reception Phone: (517) 483-1458 **Program Office Phone: (517) 483-1457** **FAX: (517) 483-9925**

GENERAL PATIENT INFORMATION

Today's Date: ________________________

Last Name:___________________________First Name:____________________________MI:___________

If Child, Parent or Guardian's Name: ____

Address:____

City, State, Zip: ____

Home Phone:_____________________Work Phone:______________Ext:_____Cell Phone: ____________

Birth Date:_________________________Gender: ☐ Male ☐ Female

Emergency Contact:________________________ ___________________ ___________________

Name Phone Number Relationship to You

Physician Name:___________________________________Phone Number: _______________________

Dentist Name: ___________________________________Phone Number: _______________________

The LCC Dental Hygiene Clinic utilizes the *phone system* for notification of patient appointments. This process may include leaving voice mail messages (check all that apply)

☐ Home or Cell number:_______________	☐ Work number: _________________
☐ OK to leave a detailed message on machine/phone	☐ OK to leave a detailed message on machine/phone
☐ OK to leave a message with call-back number only	☐ OK to leave a message with call-back number only
☐ OK to leave message with family member	☐ OK to leave message with family member
Who?_____________________	Who? ___________________

UPDATE **- USE THIS SECTION ONLY IF INFORMATION LISTED ABOVE HAS CHANGED**

Today's Date: ______________________

Last Name:________________________First Name:___________________________MI:_____

If Child, Parent or Guardian's Name: ____

Address:____

City, State, Zip: ____

Home Phone:__________________Work Phone:______________Ext:____ Cell Phone: _________

Birth Date:________________________ Gender: Male ☐ Female ☐

Emergency Contact: ______________________ ______________ _________________

Name Phone Number Relationship to You

Physician Name:________________________________Phone Number: ______________________

Dentist Name: ________________________________Phone Number: ______________________

LANSING COMMUNITY COLLEGE | DENTAL HYGIENE PROGRAM

Patient Name ______________________________ Date of Birth ______________

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Question			
Are you under a physician's care now?	YES	NO	If yes, please explain: ________________
Have you ever been hospitalized or had a major operation?	YES	NO	If yes, please explain: ________________
Have you ever had a serious head or neck injury?	YES	NO	________________
Are you taking any medication, pills, or drugs?	YES	NO	If yes, please explain: ________________
Do you take, or have you taken, Phen-Fen or Redux?	YES	NO	If yes, please explain: ________________
Are you on a special diet?	YES	NO	________________
Do you use tobacco?	YES	NO	________________
Do you use controlled substances?	YES	NO	

Women: Are you….
Pregnant/Trying? Yes or No Taking oral contraceptives? Yes Or No Nursing? Yes Or No

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics
O Other If yes, please explain: ________________

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Dental Anxiety	Yes No	Hepatitis A	Yes No	Rheumatism	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis B or C	Yes No	Scarlet Fever	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Herpes	Yes No	Shingles	Yes No
Anemia	Yes No	Easily Winded	Yes No	High Blood Pressure	Yes No	Sickle Cell Disease	Yes No
Angina	Yes No	Emphysema	Yes No	Hives or Rash	Yes No	Sinus Trouble	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	Hypoglycemia	Yes No	Spinal Bifida	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Irregular Heartbeat	Yes No	Stomach/Intestinal	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Kidney Problems	Yes No	Stroke	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Leukemia	Yes No	Swelling of Limbs	Yes No
Blood Clots/Disease	Yes No	Frequent Cough	Yes No	Liver Disease	Yes No	Thyroid Disease	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Low Blood Pressure	Yes No	Tonsillitis	Yes No
Breathing Problem	Yes No	Frequent Headaches	Yes No	Lung Disease	Yes No	Tuberculosis	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Mitral Valve Prolapse	Yes No	Tumors or Growths	Yes No
Cancer	Yes No	Glaucoma	Yes No	Pain in Jaw Joints	Yes No	Ulcers	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Parathyroid Disease	Yes No	Venereal Disease	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Psychiatric Care	Yes No	Yellow Jaundice	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Radiation Treatments	Yes No	OTHER:	
Congenital Heart Disorder	Yes No	Heart Pace Maker	Yes No	Recent Weight Loss	Yes No		
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Renal Dialysis	Yes No		
Cortisone Medicine	Yes No	Hemophilia	Yes No	Rheumatic Fever	Yes No		

Have you ever had any serious illness not listed above? Yes Or No If yes, please explain: ________________

Comments: ____

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 dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN ______________________ DATE ______________

LANSING COMMUNITY COLLEGE | DENTAL HYGIENE PROGRAM

DENTAL HISTORY

1. What is your major dental concern? ____
2. Do you have any dental condition that is causing you pain?________________________________
3. Date of your last visit to a dentist?___/___/____Reason for last visit?_________________________
4. Where did you have your most recent dental x-rays taken (please circle)? LCC DH Clinic or Personal Dentist
   If you last had dental x-rays taken by your personal dentist, what was the date that those-rays were taken?___/___/___How many x-rays were taken?____________

YES NO 5. Have you ever fainted or had other complications during or following a dental visit? _________

YES NO 6. Have you experienced an unusual reaction to dental medication or anesthetic? ________________

YES NO 7. Have you experienced prolonged bleeding following dental treatment?_____________________

YES NO 8. Have you had any other complications following dental treatment?________________________

YES NO 9. Have you had any injury to your teeth, jaws or face?____________________________________

YES NO 10. Would you change anything about the appearance of your teeth?___________________________

YES NO 11. Do your gums bleed when you brush your teeth? _____________________________________

YES NO 12. Does food or dental floss catch between your teeth?___________________________________

YES NO 13. Do any of your teeth feel loose?____

YES NO 14. Are there spaces between your teeth now where there were none before? __________________

YES NO 15. Are you worried about receiving dental treatments?___________________________________

YES NO 16. Have you ever had periodontal surgery (gum surgery)?__________________________________

YES NO 17. Have you ever had orthodontics to straighten your teeth?_______________________________

YES NO 18. Have you ever had a root canal or dental implant?_____________________________________

YES NO 19. Have you ever had teeth extracted?____

YES NO 20. Have you ever had any missing teeth replaced by a removable denture or fixed bridge?_________

YES NO 21. Do you have any other questions, concerns or additional information?______________________

YES NO 22. How often do you have your teeth cleaned? Every 6 mo. 1 yr. 2 yrs. 3-5 yrs. 10+ yrs. Never

YES NO 23. Do you use dental floss? If Yes, how often? Daily Weekly Monthly When Needed

24. How often do you brush your teeth? 2-3X Daily 1 X Daily Seldom

25. What kind of toothbrush do you use? Soft Bristles Medium Bristles Hard Bristles

YES NO 26. Do you use any other oral hygiene products not mentioned here? _________________________

YES NO 27. Is there fluoride in your drinking water?____

YES NO 28. Do you use or have you ever used any other form of fluoride?____________________________

YES NO 29. Do any members of your family wear dentures?____

YES NO 30. Do most members of your family keep their teeth all their lives? _________________________

Signature of Patient: To the best of my knowledge, the answers I have given are accurate and truthful. I also understand it is very important to report any changes in my medical or dental status to the student dental hygienists performing my preventive dental care, and I agree to do so. I give permission to the dentist to obtain from my physician any additional information regarding my medical history needed to provide me the best dental treatment possible.

Signature____Date___/____/_____

If other than patient, indicate relationship:_______________________________________

LANSING COMMUNITY COLLEGE | DENTAL HYGIENE PROGRAM

Patient Name:____ **Date of Birth:** ________________

FOR USE BY DENTAL HYGIENE STUDENT ONLY – PLEASE SKIP

Do you have now, or have you had:	**Y**	**N**	**Support Information**
Unusual reaction to medication?			
Severe or frequent headaches?			
Problems with your eyes, ears, or nose?			
Any other health problems we should know about?			
Food allergies?			
Gained or lost weight in recent months?			
Drink alcohol?			Daily___2X Week___Weekly____Less____
Date of last visit to Dr.			

FOR USE BY DENTAL HYGIENE STUDENT ONLY–

Medical History Updates: (To be used for appointments in a series or place R to indicate recall)									
Date									
Blood Pressure									
Pulse									
Resp.									
Temp.									
Medical History has been updated:									
Patient Initial									
Student Initial									
Faculty Initial									
Ask if there have been any changes in patient's address, dentist, physician information, or emergency contact. If so, edit the information and give to the front desk for data entry.									

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SCREENING APPOINTMENT:

- Only brief medical history taken, comprehensive medical history must be taken by student ***prior to Any*** treatment

Vital Signs: R Arm L Arm Sitting BP_________/_________

Patient Initials:____________Student Initials: __________Faculty Initials:_____________

ADDITIONAL HISTORY AND NOTATION OF SIGNIFICANT FINDINGS BY STUDENT AND/OR ATTENDING FACULTY

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