Texas Woman's University
Dental Hygiene Program

Date: _____

PATIENT INFORMATION

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

Address: _____ City: _____ State/Zip: _____

Phone: _____ Work Phone: _____ Email: _____

Date of Birth: _____ Occupation: _____

Emergency contact: Name: _____ Phone number: _____

I would prefer to receive correspondences via: ☐ Phone call ☐ Email ☐ Text

Race: ☐ Caucasian/White ☐ African American or Black ☐ Hispanic or Latino ☐ Asian or Asian American
☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race

Sex at Birth: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Transgender ☐ Nonbinary

Preferred Pronoun(s) or Prefix: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

MEDICAL HISTORY

Do you have a primary care physician/doctor? ☐ Yes ☐ No

Name of physician or medical home and phone number: _____
When was your last physical examination? _____

Answer the following statements below:

I've had a serious head or neck injury?	☐ Yes	☐ No	I'm on a special diet?	☐ Yes	☐ No
I have a family history of diabetes?	☐ Yes	☐ No	I've been hospitalized	☐ Yes	☐ No
I have a family history of cancer?	☐ Yes	☐ No	I've had a surgery?	☐ Yes	☐ No

MENTAL HEALTH

Check if you have or have had any of the following for more than 2 weeks.

☐ Little interest/ pleasure/ enjoy. ☐ Afraid to talk about your feelings. ☐ Feeling sad or depressed.
☐ Feel anxious/ restless/ worrisome. ☐ Had/have thoughts of suicide. ☐ N/A
If you've answered yes to any questions above, have you sought help? ☐ Yes ☐ No

HEALTH STATUS

Women please check all that apply: ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ N/A

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

Do you use controlled/illegal substances? ☐ Yes ☐ No

Please check if you have or had any of the following conditions below.

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

Have you ever had any serious illness/condition not listed above? _____

MEDICATION QUESTIONNAIRE

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

Medication	Reason Taking	Medication	Reason Taking

Which of the following medications listed above have you taken before your dental appointment today?

_____

DENTAL QUESTIONNAIRE

What is the main reason for your visit today/chief concern? _____

Name of dentist and phone number. _____

Do you have regular dental visits? ☐ Yes ☐ No If yes, how often? _____

Date and Type of last X-rays? _____ When was your last dental exam? _____

When was your last teeth cleaning? _____

Please check if you have or had any of the following conditions below

Bite/chew lips or cheeks	☐ Yes	☐ No	Chronic TMJ problems	☐ Yes	☐ No
Use smokeless tobacco	☐ Yes	☐ No	Needs to improve vitamin/nutrient intake	☐ Yes	☐ No
Drink bottled water only	☐ Yes	☐ No	Gums bleed when brushing or flossing	☐ Yes	☐ No
Received a deep cleaning	☐ Yes	☐ No	Oral piercing(s)	☐ Yes	☐ No
Dentures or dentures that fit poorly	☐ Yes	☐ No	Dental implants	☐ Yes	☐ No
Family history of gum disease	☐ Yes	☐ No	Had a bad dental experience	☐ Yes	☐ No
Clench and/or grind teeth	☐ Yes	☐ No	Currently in oral pain or discomfort	☐ Yes	☐ No
Play contact sports	☐ Yes	☐ No	Nervous about dental care	☐ Yes	☐ No
History of oral cancer	☐ Yes	☐ No	Frequently snack throughout the day	☐ Yes	☐ No
Family history of diabetes	☐ Yes	☐ No	Drink tap water WITHOUT fluoride	☐ Yes	☐ No
Smoke tobacco or E-cig/Vape	☐ Yes	☐ No			

How many alcoholic beverages do you have in a week? _____ ☐ N/A

How many alcoholic beverages in a sitting? _____ ☐ N/A

Are you interested in tobacco cessation (do you want to quit?) ☐ Yes ☐ No ☐ N/A

What type of toothbrush do you use? _____

How often and when do you brush? _____ How long do you brush for? _____

Do you use a fluoride toothpaste? What brand/type of toothpaste? _____

Do you use mouth rinse? If yes, what type?_____

Do you clean between your teeth? If so, how often and what do you use? _____

Overall, how would you rate the health of your teeth and gums? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

How important is your oral health to you? ☐ Not important ☐ Somewhat important ☐ Important
☐ Very important ☐ Extremely important

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