Parkland College Dental Hygiene Clinic

2400 West Bradley Avenue • Champaign, IL 61821
dhg@parkland.edu
(217)351-2221

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ (Last) ____________ (First) ____ (MI) ____________ (Preferred Name)

Title: ________ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ________ **Prev. Visit:** ________ **Email Address:** ____________

Phone: ________ (Home) ________ (Mobile) ________ (Work) ____ (Ext) **Best time to call:** ____________

Address: ____________ (Address 1) ____________ (Address 2)

____________ (City) ______ (State) _____-____ (Zip Code)

What is your preferred pronoun?

☐ He ☐ She ☐ They ☐ Ve ☐ Xe ☐ Ze ☐ *Other

If other, indicate below: ____________

What is your Physician's name, address, and phone number?

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What is your Dentist's name, address, and phone number?

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Which do you prefer in the case of an emergency- 911?

☐ Carle ☐ OSF (formerly known as Presence Covenant or Provena)

What is your occupation?

____

____

Height/Weight? ____________

Has there been any change in your general health within the past year? ◯ Yes ◯ No

When was your last visit to a physician? ____________

What was the reason for the visit?

____

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Are you under the care of a physician? ◯ Yes ◯ No

If yes, what is the condition being treated?

Has your physician told you to take antibiotics before any dental treatment? ◯ Yes ◯ No

Have you had surgery or a serious illness within the past two years? ◯ Yes ◯ No

If yes, describe the problem and when it occured.

Do you have any physical limitations? ◯ Yes ◯ No

If yes, Describe

Do you have or have you ever had:

1. ALLERGIES

☐ *a. Latex
☐ *b. Drugs (What?)
☐ *c. Local Anesthetics
☐ d. Other (food, animals, dust, pollen)

If yes to any ALLERGIES, please list allergen and what type of reaction occurs:

2. NEUROLOGIC

☐ *a. Epilepsy, seizures, or convulsions
☐ *b. Fainting or dizzy spells
☐ c. Hearing problems- loss, earaches, rining
☐ *d. Intellectual and developmental disabilites (Down's Syndrome, Autism Spectrum Disorders: Autism, Asperger's Syndrome, Rett Syndrome)
☐ e. Emotional/ mental health disorders (What?)
☐ *f. Parkinson's Disease
☐ *g. Stroke (Date?)
☐ h. Severe Headaches
☐ i. Vision problems (cataracts, glaucoma, macular degeneration, detached retina)

If yes to NEUROLOGIC, please explain.

3. CARDIOVASCULAR

- ☐ *a. Coronary artery disease
- ☐ *b. Atherosclerosis/ high blood cholesterol
- ☐ *c. Angina or Chest Pain
- ☐ *d. Heart Attack (Date?)
- ☐ *e. Angioplasty (Date?)
- ☐ *f. Bypass surgery (Date?)
- ☐ *g. Stents (Date?)
- ☐ *h. Congential heart defects
- ☐ *i. Damaged heart valves
- ☐ *j. Artificial (prosthetic) heart valves
- ☐ *k. Infection in heart valves or heart (infective endocarditis)
- ☐ *l. Arrhythmias (irregular heartbeat)
- ☐ *m. Pacemaker or defibrillator (Date?)
- ☐ *n. Congestive heart failure
- ☐ *o. High blood pressure
- ☐ *p. Other heart problems (What?)
- ☐ *q. Shunt or conduit (Date?)
- ☐ *r. Short of breath after mild exercise?
- ☐ s. Need to stop while walking up a flight of stairs?
- ☐ *t. Swollen ankles?

If yes to any questions in CARDIOVASCULAR, provide details and dates:

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4. ENDOCRINE

- ☐ *a. Diabetes (Type 1, Type 2, or Gestational)
- ☐ *b. Thyroid disease (Hypo/underactive or Hyper/overactive)
- ☐ *c. Taking cortisone or other steroid
- ☐ *d Taken or currently taking gender affirming hormone treatments?

If yes to any questions in ENDOCRINE, provide details and dates:

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5. PULMONARY

- ☐ *a. Asthma (use inhaler, what brings on attack, date)
- ☐ b. Sleep apnea (wear a CPAP machine?)
- ☐ *c. Cough that lasts more than 3 weeks or produces blood?
- ☐ *d. COPD- (chronic bronchitis or emphysema)
- ☐ e. Sinus trouble
- ☐ *f. Tuberculosis (Active?_ When?_ Treatment completed?)

If yes to any questions in PULMONARY, provide details and dates:

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6. HEMATOLOGIC

- ☐ a. Blood transfusion (Date?)
- ☐ b. Hemophilia
- ☐ *c. Leukemia
- ☐ *d. Portacath (Location?)
- ☐ e. Bleed longer than normal (when/why?)

If yes to any question in HEMATOLOGIC, provide details and dates:

7. DERMAL/MUSCULOSKELETAL

- ☐ *a. Arthritis (juvenile, rheumatoid, osteoarthritis)
- ☐ *b. Artificial (prosthetic) joint (Date?)
- ☐ c. Night sweats
- ☐ d. Skin rash
- ☐ *e. Systemic lupus

If yes to any question in DERMAL/MUSCULOSKELETAL provide details and dates:

8. GENITOURINARY

- ☐ *a. Dialysis
- ☐ *b. HIV positive
- ☐ *c. Kidney, bladder problems
- ☐ d. Sexually transmitted diseases (Chlamydia, Syphilis, Gonorrhea)
- ☐ e. Oral herpes (cold sores, fever blisters)
- ☐ f. Urinate frequently

If yes to any question in GENITOURINARY, provide details and dates:

9. GASTROINTESTINAL

- ☐ a. Colitis
- ☐ *b. Crohn's disease
- ☐ c. Stomach ulcers
- ☐ d. GERD
- ☐ *e. Hepatitis
- ☐ *f. Liver disease

If yes to any question in GASTROINTESTINAL, provide details and dates:

10. OTHER CONDITION

- ☐ *a. Eating disorder (type and treatment)
- ☐ *b. Cancer (when and what type)
- ☐ *c. Chemotherapy and/or radiation therapy (when and why?)
- ☐ *d. Drug or alcohol addiction
- ☐ e. Enlarged lymph node or gland (location and how long?)
- ☐ f. Frequent sore throats (when?)
- ☐ g. Sudden weight loss (when and why?)
- ☐ *h. Transplants- Liver, kidney, other
- ☐ i. Disease, problem or condition not listed (explain)

If yes to any questions in OTHER CONDITION, provide details and date:

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Are you taking, or have taken, any diet drugs such as Pondimin (fenfluramine), Redux (dexphenfluramine), or phen-fen (fenfluramine-phentermine combination)?

◯ Yes ◯ No

Are you taking or scheduled to begin taking either of the medications, aledronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease?

◯ Yes ◯ No

Since 2001, were you treated or are you scheduled to begin treatment with intravenous bisphosphonates (aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma, or cancer?

◯ Yes ◯ No

Are you taking any nonprescription medications such as cold or sinus drugs, aspirin, natural or herbal supplements, CBD, weight control medications, or other?

◯ Yes ◯ No

If yes, explain

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Are you taking any prescription medications? (Provide details in medication list) ◯ Yes ◯ No

Are you taking your medications as directed by your physician?

◯ Yes ◯ No ◯ N/A

Are you experiencing any side effects from your medications?

◯ Yes ◯ No ◯ N/A

If yes, explain:

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Do you use any of the following?

☐ a. Alcohol ☐ b.Tobacco Products ☐ c. Marijuana (in any form) ☐ d. Vaping ☐ e. Recreational Drugs

If Yes, indicate the frequency and amount used?

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Have you received the COVID-19 vaccine? ◯ Yes ◯ No

If yes, how many doses have you received?

◯ N/A ◯ 1st dose only ◯ 1st and 2nd dose

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

What trimester?

☐ First ☐ Second ☐ Third

WOMEN ONLY: Are you breastfeeding? ◯ Yes ◯ No

ASA ______________________

MC

____

____

Listed below are the prescription medications this patient uses.
Include the following:
1. Drug Name
a. Classification
b. Reason
c. Drug Interactions/ Dental considerations

Response Date: ____________