MANOR COLLEGE
DENTAL HYGIENE PROGRAM
PATIENT MEDICAL HISTORY

PATIENT'S NAME_____**DATE OF BIRTH**_____

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 that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health?		
2. Have there been any changes in your general health in the past year? What are they?		
3. Date of your last physical exam:		
4. Physician's Name:		
Physician's Address:		
Physician's Phone No.:		
Physician's Fax No.:		
5. Are you now under the care of a physician? Why?		
6. Have you ever been hospitalized for any surgical operation or serious illness? Please explain:		
7. Have you had any abnormal bleeding?		
8. Are you on blood thinning medication? What type: **When** was your last INR Reading?_____ **What** was your last INR Reading?_____		
9. Do you bruise easily?		
10.Are you **allergic to** or have you had **reactions to**:		
Local anesthetics like Novocaine		
Penicillin or other antibiotics		
Sulfa Drugs		
Barbiturates, sedatives or sleeping pills		
Aspirin		
Iodine		
Any metals (e.g., nickel, mercury, etc.)		
Latex Rubber		
Codeine or other narcotics		
Bananas, Kiwi, food allergies, peanuts		
Do you carry an Epi-pen?		
Other/s:		
11. Have you ever taken fen-phen or redux?		

	YES	NO
12. Have you ever required a blood transfusion? Date:		
a. Have you ever been denied permission to give blood?		
13. Have you had a recent weight loss?		
a. Have you had a recent weight gain?		
14. Do you smoke or have you used chewing tobacco or snuff?		
a. How much per day?_____ b. How many Years?_____		
15. Do you or have you used controlled substances?		
a. How much per day?_____ b. How many years?_____		
16. Are you wearing contact lenses?		
17. Are you wearing hearing aids? Which ear/s?		
18a. Are you taking or have you received bisphosonate medication? (Ex. Fosamax, Boniva)		
18b. Discussed BONJ with patient		
19. Are you taking any medicine(s), including non-prescription medicine? (vitamins? Herbal supplements?) If yes, please list on chart below.		

LIST OF MEDICATIONS:

PRESCRIPTION NAME AND DOSAGE	**NON-PRESCRIPTION/ NAME & DOSAGE**

WOMEN ONLY

20. Are you pregnant or think you may be pregnant? Due Date_____		
a. Are you nursing?		
b. Are you taking birth control medication?		
c. Are you taking any hormones? Name:		

Do you have or have you ever had the following:		
	YES	NO
21. Rheumatic heart disease or rheumatic fever involving heart damage? Date:		
22. Scarlet fever involving heart damage?		
23. Heart defect or heart murmur?		
24. Mitral valve prolapse?		
25. Heart trouble, heart attack, or angina?		
26. Prosthetic (artificial) heart valve		
27. Chest pain after mild exertion?		
28. Shortness of breath when you lie down		
29. Pacemaker / Defibrillator		
30. Heart surgery, catherization		
31. High/low blood pressure		
32. Congenital heart problem		
33. Swelling of feet, ankles, hands		
34. High Cholesterol		
35. Stroke or mini stroke		
36. Fainting or dizzy spells		
37. Epilepsy or seizures (convulsions) a. Last seizure: b. Aura: c. How long do seizures last:		
38. Do you use 2 pillows to sleep?		
39. Anemia		
40. Sickle cell disease		
41. Blood disorder		
42. Hepatitis, jaundice or liver disease? Type:		
43. AIDS or HIV infection?		
44. Thyroid problems?		
45. Arthritis or rheumatism		
46. Joint replacement or implant Date:		
47. Kidney trouble		
48. Sexually transmitted disease Type:		
49. Glaucoma / cataracts		
50. Nervousness / anxiety / depression		
51. Tonsillitis		
52. Fibromyalgia		
53. Neck / Back Problems		
54. Mental Health Care a. Type: b. When:		
55. Chemical dependency		
56. Alcohol dependency		
57. Cortisone treatment		
58. Cold sores / fever blisters		
59. Sinus trouble		
60. Lung or breathing problems		

61. Tuberculosis		
62. Persistent cough		
	YES	NO
63. Cough that produces blood		
64. Asthma a. Stress induced? b. Allergy induced? c. Do you carry your inhaler?		
65. Emphyzema		
66. Gastric bypass		
67. Hayfever		
68. Immunological disease (e.g. lupus)		
69. Hives or skin rash		
70. GERD (regurgitation problems)		
71. Ulcerative Colitis / IBS		
72. Crohn's Disease		
73. Hiatal Hernia		
74. Stomach ulcer		
75. Eating Disorders		
76. Diabetes I or II		
a. Did you take insulin today?		
b. Normal glucose reading?		
77. Excessive thirst		
78. Urinate more than 6x per day?		
79. Hypoglycemia		
80. Cancer / Tumors		
81. Chemotherapy (cancer, leukemia) Date:		
82. Radiation Treatment for tumor, growth, cancer, etc.		
83. Breast Cancer		
a. Nodes removed		
b. Which arm		
84. Other conditions not listed:		

COMMENTS: Do you have any hearing or visual problems or other disabilities?

_____

_____

_____

_____

_____

Patient Signature
Date

_____

Manor Staff Signature
Date

3/08; 3/31/08; 6/11/08; 8/11/08; 5/29/09; 8/25/09

Manor College
Expanded Functions Dental Assisting Program

Participant Informed Consent Statement

I the under signed, hereby acknowledge that I have voluntarily agreed to participant in the EFDA Coronal Polishing/Fluoride Application course at Manor College. Upon registration for this course, I understand I will be performing and receiving treatment in the form of coronal polishing and fluoride application as a condition of course completion. The procedures will take place in the Manor Dental Health Center with direct faculty supervision and according to applicable laws, regulations and safety standards.

I have completely and accurately revealed and described my previous and current medical conditions on my health history form. I have included on the medical history any prescription or over the counter medications I am presently taking.

I understand that if I have any health concerns (ie: uncontrolled hypertension, allergies to materials being used or oral lesions) or dental concerns (ie: porcelain veneers, porcelain or gold crowns, dental implants, uncontrolled periodontal conditions, recent periodontal treatment or previous cosmetic restorations) that will not exclude me from participation in the training, but will preclude me from receiving coronal polishing and fluoride treatment, I will provide a substitute over the age of 18 to serve as a patient to receive treatment on my behalf. If I require a substitute, I will notify Manor College two (2) days prior to the course and my substitute will be required to provide a medical history and informed consent.

I understand there is a possibility that I may experience discomfort during coronal polishing and /or fluoride application. I also understand that there are certain risks entailed in polishing and fluoride application including, but not limited to local complications such as: hypersensitivity, gingival trauma, soft tissue trauma, hard tissue trauma, and damage, dislodging and /or abrasion to existing restorations. Gastrointestinal upset may occur during and following fluoride application. Severe allergic and possible life threatening reactions necessitating emergency care are uncommon but could occur. I am willing to undertake the risk of performing and receiving coronal polishing and fluoride applications.

I hereby knowingly, freely, and voluntarily releases and hold harmless the Commonwealth of Pennsylvania, Higher Education Council , Manor College and their agents, employees, servants, students and assignees from any and all liability, claims, demands or causes of action whatsoever, including liability for negligence, arising out of any damage or injury which I might suffer in the course of , or related to, participation tine the Expanded Function Dental Assisting Coronal Polishing and Fluoride Application course at Manor College.

I acknowledge reading and reviewing this consent. I have given a complete and truthful medical history, including all medication, drug use, pregnancy, etc. I certify that I speak, read and write English.

If you have any questions, PLEASE ASK.

Participant's Name (print):_____

Participant's Signature:_____Date:_____

If applicable
Patient Substitute Name (print):_____

Patient Signature:_____ Date:_____

Course Coordinator Signature:_____ Date:_____

10/24/2010

MANOR COLLEGE
EFDA PROGRAM

CORONAL POLISHING COURSE

CONSENT FOR USE OF IMAGE(S)

On occasion, photographs, videotape or other images of students, patients, faculty, etc. are taken during activities by the Expanded Functions Dental Assisting (EFDA) Program or under the program's direction and then presented sin various publications, such as in news releases, on the Web site, in the College newsletter, etc. Everyone, including the program benefit in numerous ways by publicly recognizing their accomplishments in program events.

We are asking you to sign the form below granting us permission to use your photograph in any College or program publication, on the Web site or in any news release to the media.

I, _____(print full name) give consent for Manor College and the EFDA Program to use my image in various forms of media, including, but not limited to, photographs, websites, video images, news media, etc.

There is no expiration of this consent unless you notify the program otherwise.

_____ _____
Signature Date

Rev'd SAHS, 2006
8.25.06

MANOR COLLEGE
EFDA PROGRAM

Medical Clearance and Contraindications For Coronal Polishing

Medical clearance **must** be obtained prior to coronal polishing for any of the following conditions:

a. Rheumatic fever or rheumatic heart disease
b. Congenital heart lesions
c. Other cardiovascular diseases, if indicated
d. Diabetes (poorly controlled or unmonitored within the past 6 months)
e. Hepatitis, jaundice, liver disease
f. Tuberculosis (see clinic guidelines for adapting treatment)
g. Existing sexually transmitted diseases
h. Blood disease, such as leukemia or hemophilia
i. Epilepsy or other seizure disorders
j. Kidney disease, dialysis clients or history of a transplant, renal disease
k. High blood pressure (See clinic guidelines)
l. Use of anticoagulants or antiplatelets
m. Use of corticosteroids
n. HIV or AIDS related complex
o. Organ transplant
p. Joint replacements, orthopedic screws or pins
q. Phen-Phen and Redux
r. Pregnancy
s. Existing oral lesions (ie. Herpetic or aphthous)
t. Any patient that requires premedication antibiotics

7/19/10