PART 2

Assessment Skills

MODULE
5

MEDICAL HISTORY

MODULE OVERVIEW

The medical history is a critical step in the care of every dental patient. The medical history provides important information related to the patient's physical and psychological condition. The information gathered during the medical history is ultimately used when determining how a patient's systemic health may be impacted by the planned dental care. This information allows the clinician to determine whether dental treatment alterations are necessary for the patient to safely undergo each specific dental procedure.

In addition, a thorough understanding of the implications of the findings from the medical history is a critical component in interprofessional collaboration. One of the key foundations of the concept of interprofessional practice is for all health care providers to share a common vocabulary and common understanding of caring for the patient as a whole. A thorough health history is the first step for a dental hygienist or dentist to participate in collaborating with other health care providers about the overall welfare of a patient.

This module covers taking and interpreting the medical history, including:

- Gathering information regarding a patient's medical conditions and diseases
- Gathering information regarding a patient's medications and supplements
- Informed consent and the medical history
- Determining how a patient's medical conditions and/or medications impact dental care

MODULE OUTLINE

KEY TERMS

Multi-Language Health History Project • Medical risk • Interprofessional collaborative practice • Medical consult • Informed consent • Capacity for consent • Informed refusal • Information-gathering phase • Medical alert box

OBJECTIVES

- Recognize the manifestations of systemic disease and how the disease and its management may affect the delivery of dental care. Demonstrate skills in conducting online research on medical conditions/diseases and medications.
- Demonstrate the use of communication strategies and questioning techniques that facilitate complete, accurate information gathering.
- Recognize the need for conducting risk assessments on dental patients.
- Communicate effectively with individuals from diverse populations.
- Discuss the ways in which a hygienist's choice of words can facilitate or hinder communication with patients regarding patient assessment procedures.
- Apply principles of risk management, including informed consent and appropriate record keeping in patient care.
- Demonstrate skills necessary to obtain a complete and thorough medical history.
- Describe the types of information that should be entered in the medical alert box on the medical history form.
- Participate with dental team members and other health care professionals in the management and health promotion for all patients.
- Practice within one's scope of competence and consult with or refer to professional colleagues when indicated.
- Describe contraindications and complications for dental care presented by various medical conditions/diseases and medications.
- Identify findings that have implications in planning dental treatment.
- Provide appropriate referral to a physician or dental specialist when findings indicate the need for further evaluation.
- Demonstrate the ability to apply information learned in the classroom and clinical activities to the fictitious patient cases A to E in this module, including reviewing completed health history forms, conducting research, formulating follow-up questions, conducting a patient interview, and determining the medical risk of dental treatment to the patient.

SECTION 1 • The Health History

A health history form is used to gather subjective data about the patient and explore past and present problems. Health history forms assist patients in providing an account of their health history.

- Health history forms are available in many different formats and lengths.
- Many health history forms include a list of diseases and medical conditions that aid patients in recalling their medical history.
- Most forms ask the patient to check a box or circle "yes" or "no" for each question or item on the form. Some health history forms have space that allows patients to provide additional information in response to questions and to list their medications.
- Regardless of the format or length, the health history form should provide the health care professional with complete information regarding the past and present health of each patient.

Caring for Patients in a Multicultural Society

The United States and Canada are multicultural societies where many residents report being born in a foreign country. This diversity in ethnicity, culture, and language enriches these countries, but it also complicates efforts to provide safe dental care.

- For many dental health care providers in the United States and Canada, assessing a patient's history involves finding a way to communicate with patients who speak another language.
- Ideally, an interpreter who is specially trained to conduct translations involving medical and dental terminology, conditions, and procedures would be a member of every dental staff. However, employing a trained medical/dental interpreter who is fluent in many different languages is an unrealistic option for most dental offices and clinics.
- Using a health history form that has been translated into different languages is a more practical solution to the problem of obtaining history information from non-English-speaking patients.

Multi-Language Health History Project

The **Multi-Language Health History Project** began as an initiative of the University of the Pacific (UOP) Arthur A. Dugoni School of Dentistry to address the needs of patients and dental health care providers who do not speak the same language. With the assistance of the California Dental Association and MetLife Inc., the history form has been translated into over 25 different languages. Transcend, a California company specializing in translations services certifies that the translations are correct.

Obtaining and Using the University of the Pacific Multi-Language Forms

- Directions for downloading copies of the UOP multi-language health history forms are found in Box 5-1.
- The English version of the UOP health history form was translated into over 25 different languages, keeping the same question numbering sequence. Using a translated form, a dental health care provider who speaks English and is caring for a patient who doesn't can ask the patient to complete the health history in his or her own language.

- The clinician then compares the English health history to the patient's translated health history, scanning the translated version for "yes" responses. When a "yes" is found, the dental health care provider is able to look at the question number and match it to the question number on the English version. For example, question 34 on the Japanese version is the same as question 34 on the English version and relates to high blood pressure.
- In the same manner, a dental health care provider who speaks Spanish could use the multi-language health history form with a patient who speaks French. A few examples of the UOP health history form are shown in Figures 5-1 to 5-4.
- The UOP multi-language health history form is used in each of the fictitious patient activities that appear at the end of this module.

BOX 5-1

Instructions for Downloading the University of the Pacific Multi-Language Forms

The multi-language health history forms can be downloaded at no cost on the Internet.

1. Connect a computer to the Internet and open an Internet browser.
2. On an Internet browser, enter the website address in the rectangular box near the top of the browser:
   - http://oralfitnesslibrary.com/Multi-Language-Health-History-Forms
   - Click on "GO" or hit the "return key" on the keyboard. The selected web page should open.

NOTE: A software application—**Adobe Acrobat Reader**—is needed to open and view a pdf document and can be downloaded at http://get.adobe.com/reader.

MetLife

HEALTH HISTORY

English

University of the Pacific

Patient Name:_____ Patient Identification Number:_____

Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____ Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	40.	Yes	No	AIDS
30.	Yes	No	Heart attack, heart defects?	41.	Yes	No	Tumors, cancer?
31.	Yes	No	Heart murmurs?	42.	Yes	No	Arthritis, rheumatism?
32.	Yes	No	Rheumatic fever?	43.	Yes	No	Eye diseases?
33.	Yes	No	Stroke, hardening of arteries?	44.	Yes	No	Skin diseases?
34.	Yes	No	High blood pressure?	45.	Yes	No	Anemia?
35.	Yes	No	Asthma, TB, emphysema, other lung diseases?	46.	Yes	No	VD (syphilis or gonorrhea)?
36.	Yes	No	Hepatitis, other liver disease?	47.	Yes	No	Herpes?
37.	Yes	No	Stomach problems, ulcers?	48.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Allergies to: drugs, foods, medications, latex?	49.	Yes	No	Thyroid, adrenal disease?
39.	Yes	No	Family history of diabetes, heart problems, tumors?	50.	Yes	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	No	Psychiatric care?	56.	Yes	No	Hospitalization?
52.	Yes	No	Radiation treatments?	57.	Yes	No	Blood transfusions?
53.	Yes	No	Chemotherapy?	58.	Yes	No	Surgeries?
54.	Yes	No	Prosthetic heart valve?	59.	Yes	No	Pacemaker?
55.	Yes	No	Artificial joint?	60.	Yes	No	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	No	Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing? 66. Yes No Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

RECALL REVIEW:

1. Patient's signature_____ Date:_____
2. Patient's signature_____ Date:_____
3. Patient's signature_____ Date:_____

The Health History is created and maintained by the University of the Pacific School of Dentistry, San Francisco, California.
Support for the translation and dissemination of the Health Histories comes from MetLife Dental Care.

FIGURE 5-1 History form in English. Shown here is the University of the Pacific Arthur A. Dugoni School of Dentistry's health history form in English.

MetLife **University of the Pacific**

DOSSIER MÉDICAL
French

Nom du patient/de la patiente : _____ No d'identification du patient : _____

Date de naissance : _____

I. ENTOURER LA MENTION CORRESPONDANTE (laisser en blanc si la question n'est pas comprise) :

1. Oui Non Êtes-vous en général en bonne santé ?
2. Oui Non Votre état de santé a-t-il changé depuis l'année dernière ?
3. Oui Non Avez-vous été hospitalisé(e) ou avez-vous été gravement malade au cours des trois dernières années ?
   Si vous avez répondu OUI, pour quelle raison/maladie ? _____
4. Oui Non Êtes-vous actuellement en traitement médical sur ordre d'un médecin ? Pour quelle maladie ? _____
   Date du dernier examen médical _____ Date du dernier examen dentaire _____
5. Oui Non Avez-vous eu des problèmes avec un traitement dentaire précédent ?
6. Oui Non Souffrez-vous actuellement ?

II. AVEZ-VOUS DÉJÀ EU :

7.	Oui	Non	Douleurs thoraciques (angine de poitrine) ?	18.	Oui	Non	Vertiges ?
8.	Oui	Non	Chevilles enflées ?	19.	Oui	Non	Bourdonnement d'oreilles ?
9.	Oui	Non	Essoufflement ?	20.	Oui	Non	Maux de tête ?
10.	Oui	Non	Perte de poids, fièvre, sueurs nocturnes, récemment ?	21.	Oui	Non	Pertes de connaissance ?
11.	Oui	Non	Toux persistante, toux sanglante ?	22.	Oui	Non	Troubles de la vision ?
12.	Oui	Non	Problèmes de saignements, contusions fréquentes ?	23.	Oui	Non	Crises d'épilepsie ?
13.	Oui	Non	Problèmes de sinus ?	24.	Oui	Non	Soif excessive ?
14.	Oui	Non	Difficultés à avaler ?	25.	Oui	Non	Urination fréquente ?
15.	Oui	Non	Diarrhées, constipation, sang dans les selles ?	26.	Oui	Non	Xérostomie (bouche sèche) ?
16.	Oui	Non	Vomissements fréquents, nausées ?	27.	Oui	Non	Jaunisse ?
17.	Oui	Non	Difficultés à uriner, sang dans les urines ?	28.	Oui	Non	Douleurs articulaires, raideur articulaire ?

III. AVEZ-VOUS ACTUELLEMENT OU AVEZ-VOUS EU :

29.	Oui	Non	Maladie du cœur ?	40.	Oui	Non	SIDA?
30.	Oui	Non	Crise cardiaque, malformations cardiaques ?	41.	Oui	Non	Tumeurs, cancer ?
31.	Oui	Non	Souffles au cœur ?	42.	Oui	Non	Arthrite, rhumatismes ?
32.	Oui	Non	Rhumatisme articulaire aigu ?	43.	Oui	Non	Maladies oculaires ?
33.	Oui	Non	Accident vasculaire cérébral, durcissement des artères ?	44.	Oui	Non	Maladies de peau ?
34.	Oui	Non	Hypertension ?	45.	Oui	Non	Anémie ?
35.	Oui	Non	Asthme, tuberculose, emphysème pulmonaire, autres maladies pulmonaires ?	46.	Oui	Non	MST (syphilis ou blennorragie) ?
				47.	Oui	Non	Herpès ?
36.	Oui	Non	Hépatite, autres maladies du foie ?	48.	Oui	Non	Maladies rénales, de la vessie ?
37.	Oui	Non	Problèmes d'estomac, ulcères ?	49.	Oui	Non	Maladies thyroïdiennes, surrénales ?
38.	Oui	Non	Allergies : médicaments, aliments, produits médicaux, latex ?	50.	Oui	Non	Diabète ?
39.	Oui	Non	Antécédents familiaux de diabète, problèmes cardiaques, tumeurs ?				

IV. AVEZ-VOUS ACTUELLEMENT OU AVEZ-VOUS EU :

51.	Oui	Non	Soins psychiatriques ?	56.	Oui	Non	Hospitalisation ?
52.	Oui	Non	Radiothérapie ?	57.	Oui	Non	Transfusions sanguines ?
53.	Oui	Non	Chimiothérapie ?	58.	Oui	Non	Opérations chirurgicales ?
54.	Oui	Non	Valvule prothétique ?	59.	Oui	Non	Stimulateur cardiaque (Pacemaker) ?
55.	Oui	Non	Articulation artificielle ?	60.	Oui	Non	Lentilles de contact ?

V. CONSOMMEZ-VOUS ACTUELLEMENT :

61.	Oui	Non	Drogues à usage récréatif ?	63.	Oui	Non	Tabac (sous toutes ses formes) ?
62.	Oui	Non	Médicaments sur prescription, des médicaments obtenus sans ordonnance médicale (dont l'Aspirine), des remèdes naturels ?	64.	Oui	Non	Alcool ?

Veuillez indiquer : _____

VI. POUR LES FEMMES UNIQUEMENT :

65.	Oui	Non	Êtes-vous actuellement ou pourriez-vous être enceinte ou allaitez-vous ?	66.	Oui	Non	Prenez-vous actuellement des pilules contraceptives ?

VII. TOUS PATIENTS :

67. Oui Non Avez-vous actuellement ou avez-vous eu toute autre maladie ou tout autre problème médical NON indiqué sur ce formulaire ?

Si tel est le cas, veuillez expliquer : _____

Je soussigné(e), déclare avoir répondu à chaque question le plus complètement et précisément possible, dans la mesure de mes connaissances. Je m'engage à informer mon dentiste de tout changement dans mon état de santé et (ou) de toute prise de médicaments.

Signature du patient/de la patiente : _____ Date : _____

REVUE DE RAPPEL :

1. Signature du patient/de la patiente _____ Date : _____
2. Signature du patient/de la patiente _____ Date : _____
3. Signature du patient/de la patiente _____ Date : _____

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FIGURE 5-2 **History form in French.** Shown here is the University of the Pacific Arthur A. Dugoni School of Dentistry's health history form in French. The University of the Pacific health history form in English was translated, keeping the same question numbering sequence so that a clinician can compare the English health history to the patient's translated health history.

MetLife **健康記錄** Chinese **University of the Pacific**

姓名: _____ 病人身份號碼: _____
出生日期: _____

I. 選擇適當答案（若不知道請留空）:

1. 是 否 您的健康是否良好?
2. 是 否 過去一年您的健康有沒有改變?
3. 是 否 過去三年有沒有住院或患重病?
   如果有，什麼原因? _____
4. 是 否 您現在是否在接受醫生治療? 什麼原因? _____
   上次全身檢查是何時: _____ 上次牙科檢查是何時: _____
5. 是 否 牙齒治療之後是否有過問題?
6. 是 否 您現在有無痛楚?

II. 您曾否有下列症狀或疾病:

7. 是 否 胸痛（狹心病）?
8. 是 否 腳踝腫?
9. 是 否 呼吸急促?
10. 是 否 最近體重減輕，發燒，夜汗?
11. 是 否 咳嗽，咳血?
12. 是 否 流血問題，容易發瘀?
13. 是 否 鼻竇問題?
14. 是 否 吞食問題?
15. 是 否 腹瀉，便秘，便血?
16. 是 否 嘔吐，噁心?
17. 是 否 小便困難，尿血?
18. 是 否 頭暈?
19. 是 否 耳鳴?
20. 是 否 頭痛?
21. 是 否 暈眩?
22. 是 否 眼花?
23. 是 否 癲癇（羊癲瘋）?
24. 是 否 極度口渴?
25. 是 否 尿頻?
26. 是 否 口乾?
27. 是 否 黃膽?
28. 是 否 關節疼痛，僵硬?

III. 您現在或過去是否有下列疾病:

29. 是 否 心臟衰弱?
30. 是 否 心臟病發作，心臟有缺陷?
31. 是 否 心雜音?
32. 是 否 風濕熱?
33. 是 否 中風，血管硬化?
34. 是 否 高血壓?
35. 是 否 哮喘、肺結核、肺氣腫或其他肺疾病?
36. 是 否 肝炎或其他肝病?
37. 是 否 胃病（潰瘍）?
38. 是 否 食物、藥物或橡膠製品過敏?
39. 是 否 家族中有無糖尿病、心臟病、腫瘤病史?
40. 是 否 愛滋病?
41. 是 否 腫瘤? 癌症?
42. 是 否 風濕性關節炎?
43. 是 否 眼病?
44. 是 否 皮膚病?
45. 是 否 貧血?
46. 是 否 性病（梅毒、淋病）?
47. 是 否 皰疹?
48. 是 否 腎病、膀胱病?
49. 是 否 甲狀腺、腎上腺病?
50. 是 否 糖尿病?

IV. 您現在或過去是否有下列的疾病或治療:

51. 是 否 精神病治療?
52. 是 否 放射性治療?
53. 是 否 化學治療?
54. 是 否 人工心臟瓣膜?
55. 是 否 人工關節?
56. 是 否 住院?
57. 是 否 輸血?
58. 是 否 手術?
59. 是 否 心律調節器?
60. 是 否 隱形眼鏡?

V. 您現在是否服用:

61. 是 否 迷幻藥?
62. 是 否 處方藥品、一般藥品（包括: 阿司匹林）或天然藥材?
63. 是 否 香煙、雪茄或其他煙草製品?
64. 是 否 飲酒?

請說明: _____

VI. 只限女士們:

65. 是 否 您是否現在懷孕或哺乳，或可能懷孕?
66. 是 否 服避孕藥?

VII. 所有病者:

67. 是 否 您現在或以前是否有任何本表格中**沒有**列出的病症?

請說明: _____

我已經盡我所知完整及準確地回答上述每一個問題。 若有任何身體狀況或服藥方面的變化，我將通知我的牙科醫生。

簽名: _____ 日期: _____

覆診:

1. 簽名: _____ 日期: _____
2. 簽名: _____ 日期: _____
3. 簽名: _____ 日期: _____

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FIGURE 5-3 History form in Chinese. Shown here is the University of the Pacific Arthur A. Dugoni School of Dentistry's health history form in Chinese. The University of the Pacific health history form in English was translated, keeping the same question numbering sequence so that a clinician can compare the English health history to the patient's translated health history.

MetLife **تاریخچه تندرستی** **University of the Pacific**

Farsi

نام بیمار: _____ شماره شناسائی بیمار: _____

تاریخ تولد: _____

I. دور جواب درست دایره بکشید.(اگر سئوالی را متوجه نمیشوید جایش را خالی بگذارید):

1. بله خیر آیا از سلامت کامل برخوردارید؟
2. بله خیر آیا در یك سال اخیر تغییری در سلامتی شما حاصل شده است؟
3. بله خیر آیا در سه سال اخیر به علت بیماری مهمی در بیمارستان بستری شده اید؟
   چرا؟ _____
4. بله خیر آیا در حال حاضر تحت نظر پزشکی هستید؟ به چه عنوان؟ _____
   تاریخ آخرین معاینه پزشکی _____ تاریخ آخرین معاینه دندانپزشکی _____
5. بله خیر آیا با معالجات گذشته دندانپزشکی مشکل داشته اید؟
6. بله خیر آیا در حال حاظر درد دارید؟

II. آیا تجربه کرده اید:

7. بله خیر درد سینه (آنژین)؟
8. بله خیر تورم مچ پا؟
9. بله خیر نفس تنگی؟
10. بله خیر کاهش وزن ، تب ، عرق کردن هنگام شب؟
11. بله خیر سرفه پی در پی، سرفه توام با خون؟
12. بله خیر خونریزی ، کبود شدن سریع؟
13. بله خیر بیماری سینوس؟
14. بله خیر اشکال در بلعیدن؟
15. بله خیر اسهال، یبوست، خون در مدفوع؟
16. بله خیر استفراغ مکرر، حالت تهوع؟
17. بله خیر به سختی ادرار کردن، خون در ادرار؟
18. بله خیر سرگیجه؟
19. بله خیر صدای زنگ در گوشها؟
20. بله خیر سردرد؟
21. بله خیر احساس غش؟
22. بله خیر تیرگی بینائی ؟
23. بله خیر حمله ناگهانی؟
24. بله خیر تشنگی بیش از حد؟
25. بله خیر ادرار مکرر؟
26. بله خیر خشکی دهان؟
27. بله خیر زردی؟
28. بله خیر درد مفاصل ، سفتی مفاصل؟

III. آیا شما دارید یا داشته اید:

29. بله خیر بیماری قلبی؟
30. بله خیر سکته قلبی، نقص قلبی؟
31. بله خیر صدا های غیر طبیعی قلب؟
32. بله خیر تب روماتیسم؟
33. بله خیر حمله قلبی، سفت شدن سرخ رگها؟
34. بله خیر فشار خون بالا؟
35. بله خیر آسم، سل، آمفیزم، دیگر بیماریهای ریه؟
36. بله خیر هپاتیت، دیگر بیماریهای کبد؟
37. بله خیر مشکلات معده ، زخم معده؟
38. بله خیر آلرژی (حساسیت) به دوا، غذا، دارو، شیرگیاهی؟
39. بله خیر تاریخچه خانوادگی از نظر مرض قند، قلب ، غدد؟
40. بله خیر ایدز؟
41. بله خیر غده، سرطان؟
42. بله خیر التهاب مفاصل ، روماتیسم؟
43. بله خیر بیماری چشم؟
44. بله خیر بیماری پوست؟
45. بله خیر کم خونی؟
46. بله خیر بیماریهای جنسی (سفلیس سوزاك)؟
47. بله خیر تبخال؟
48. بله خیر بیماریهای کلیه ، مثانه؟
49. بله خیر بیماریهای تیروئید ، غده فوق کلیوی؟
50. بله خیر مرض قند؟

IV. آیا شما دارید یا داشته اید:

51. بله خیر معالجه روانپزشکی؟
52. بله خیر معالجات اشعه ای؟
53. بله خیر شیمی درمانی؟
54. بله خیر دریچه مصنوعی قلب؟
55. بله خیر مفصل مصنوعی؟
56. بله خیر بستری شدن در بیمارستان؟
57. بله خیر انتقال خون؟
58. بله خیر جراحی؟
59. بله خیر دستگاه تنظیم کننده ضربان قلب؟
60. بله خیر عدسی تماسی؟ (کانتکت لنز)

V. آیا شما استفاده می کنید:

61. بله خیر مواد تفریحی (مواد مخدر)؟
62. بله خیر دارو با نسخه ، بدون نسخه از قبیل (آسپرین)، مواد مخدر، دارو های طبیعی
63. بله خیر تنباکو از هر نوع؟
64. بله خیر الکل؟

لطفاً موارد بالا را لیست کنید _____

VI. خانمها فقط:

65. بله خیر آیا شما باردار هستید یا میتوانید باردار باشید و یا کودکی را شیر میدهید؟
66. بله خیر آیا شما قرص جلوگیری از حاملگی استفاده میکنید؟

VII. برای تمام بیماران:

67. بله خیر آیا شما هرنوع بیماری یا مشکلات دیگر پزشکی که در این فرم ذکر نشده است دارید یا داشته اید؟

اگر چنین است لطفا توضیح بدهید: _____

من تمام سئوالات را کاملا و دقیقا جواب داده ام . من دندانپزشکم را از هر گونه تغییراتی در سلامتی خویش یا مصرف دارو مطلع خواهم کرد.

امضاء بیمار: _____ تاریخ: _____

مراجع مجدد:

1. امضاء بیمار: _____ تاریخ: _____
2. امضاء بیمار: _____ تاریخ: _____
3. امضاء بیمار: _____ تاریخ: _____

The Health History is created and maintained by the University of the Pacific School of Dentistry, San Francisco, California.
Support for the translation and dissemination of the Health Histories comes from MetLife Dental Care.

FIGURE 5-4 History form in Farsi. Shown here is the University of the Pacific Arthur A. Dugoni School of Dentistry's health history form in Farsi. The University of the Pacific health history form in English was translated, keeping the same question numbering sequence so that a clinician can compare the English health history to the patient's translated health history.

SECTION 2 • The Medical History Assessment

Relationship between Systemic and Oral Health

There are many reasons for conducting a thorough assessment of the patient's past and current health status. The most important reason is to protect the health of the patient. There is a strong two-way relationship between systemic health and oral conditions.

- Systemic diseases and conditions may have oral implications. For example, patients with poorly controlled diabetes do not respond well to periodontal therapy.
- Medications used to treat systemic diseases and conditions can produce changes in oral health. For example, certain medications can result in gingival hyperplasia (overgrowth of the gingiva).
- Systemic conditions, diseases, or medications may necessitate precautions to ensure that planned dental treatment will not be harmful to the patient's systemic health. For example, a patient who has a history of well-controlled congestive heart failure may need certain treatment modifications such as short appointments and supplemental oxygen by nasal cannula.
- Oral manifestations may identify conditions that should be evaluated by a primary care physician. For example, periodontal disease that does not respond to treatment may be an indication of uncontrolled diabetes because this condition increases susceptibility to infection and results in slower healing rates.
- Substances, materials, or drugs used in dental treatment may produce an adverse reaction in certain patients. For example, a patient with allergies may be allergic to latex.

Dental hygienists are preventive specialists and as such are responsible for the oral and general health of their patients. Increasing numbers of patients with complex medical problems are seeking dental care.[1] The U.S. Surgeon General's Report on Oral Health emphasizes the importance of oral health and its essential role in overall general health. The report highlights the need for interdisciplinary care between dental health care providers and physicians for the joint management of systemic and oral health problems.[2] Dental hygienists play an important role in the early identification and referral of patients with medical conditions and collaboration with other health professionals for comprehensive patient care.

In the United States, the most rapidly growing segment of the population is over the age of 85 years.[3] By the year 2050, it is estimated that 56% of the U.S. population will be at least 55 years of age and 25% of the population will be at least 65 years of age.[3] As the population ages, the prevalence of chronic systemic diseases—such as diabetes and cardiovascular diseases—is increasing.

Dental Practices as Health Screening Sites

Dental practices can serve as alternate sites of opportunity to identify health concerns among diverse groups of patients.[1,4–6] Many individuals seek dental care more often than other health care services and could benefit from the screening for medical conditions in dental offices.[6] Analysis of data from a nationally representative sample of United States' households finds that 26.0% of children and 24.1% of adults ***did not*** visit a medical health care provider in 2008.[6] Of these individuals (who did not see a medical provider), 37% of the children and 23.1% of the adults visited a dental office (a total of 19.5 million people).[6] Researcher Sheila Strauss suggests that dental health care providers can help patients by (1) examining the oral cavity for signs of systemic disease elsewhere

in the body; (2) taking detailed medical histories, including information that could indicate medical conditions for follow-up; and (3) using tools such as blood pressure cuffs and finger-stick glucose monitors to check for biomarkers for such conditions as diabetes and hypertension.[6] Glucose monitors are inexpensive, and the screening can be done in less than 60 seconds. Box 5-2 outlines common methods for measuring blood glucose levels and how these findings relate to the risk of infection for planned treatment.

Risk Assessment: Physical Status

At this stage in the health history assessment process, the dental health care provider should consider the patient's **medical risk** when undergoing dental treatment. ***Modification of dental treatment may be necessary in certain medically complex patients***.[7] Today, many patients seen in the dental office have multiple medical conditions and are taking many medications. It is more difficult to manage these types of patients, and thorough assessment of their physical status is an important part of clinical practice.

The American Society of Anesthesiologists (ASA), pioneers in the field of patient safety in medical and dental care, developed a physical status system for assessing the risk to the patient of medical or dental treatment. ***The American Society of Anesthesiologists Physical Status Classification System (ASA-PS) serves an integral part of risk assessment in determining how the dental team should manage a patient***.[7,8] The ASA-PS is described in Table 5-1. This table outlines how a patient's physical status can affect the planning of dental care.

TABLE 5-1 PHYSICAL STATUS IMPLICATIONS FOR DENTAL TREATMENT

	ASA-PS Classification	Modifications for Safe Patient Care
ASA 1	• A normal healthy patient with little or no anxiety about dental treatment	• Green flag for dental treatment • No treatment modifications
ASA 2	• A patient with mild systemic disease • ASA 1 patients who are anxious or fearful of dental treatment • Examples: well-controlled diabetes, epilepsy, asthma	• Yellow flag for dental treatment • Employ stress-reduction strategies.
ASA 3	• A patient with severe systemic disease that limits activity • Examples: angina, stroke, heart attack, congestive heart failure	• Yellow flag for dental treatment • Employ stress-reduction strategies. • Treatment modifications needed, such as antibiotic premedication
ASA 4	• A patient with severe systemic disease that is a constant threat to life • Examples: heart attack or stroke within the last 6 months	• Red flag for dental treatment • Elective dental care should be postponed until patient's medical condition has improved to at least an ASA 3 classification.

BOX 5-2

Glucose Blood Levels in Diabetes

Test	Glucose Levels
Hemoglobin A_{1c}	Goal for most people with diabetes = less than 7% High susceptibility to infection = above 8%
Finger-stick test	Glucose level at appointment time: • Acceptable = 80–120 mg/dl • Risk of infection = 180–300 mg/dl • Unacceptable = greater than 300 mg/dl

Interprofessional Collaboration

Interprofessional collaborative practice occurs when multiple health workers from different professional backgrounds work together with patients and family members/carers to deliver the highest quality of care.[9] Interprofessional collaboration involves continuous interaction and knowledge sharing between professionals—such as dentistry, medicine, medical radiation sciences, nursing, occupational therapy, pharmacy, physician assistant, physical therapy, social work, and speech-language pathology—with each individual contributing within the limits of his or her scope of practice.

Interprofessional education has been identified as a critical issue in dental education. Accreditation standards for dental education contain language promoting collaboration with other health professionals.[10] Research suggests that interprofessional collaboration improves coordination, communication, and ultimately, the quality and safety of patient care. It uses both the individual and collective skills of professionals, allowing them to function more effectively and deliver a higher level of services than each would working alone.

Consultation with a Physician

If all health questions are not completely answered through research and the patient interview, or if there is any question or doubt in making the best decisions, consulting with the patient's physician is necessary. A **medical consult** is simply a request for additional information and/or advice about the medical implications of oral health care treatment. A written request and reply referral is ideal because there is no doubt about either the question or the answer. Figures 5-5A and 5-5B provide an example of a two-page written request form for consultation with a physician.

1. **Request in Writing.** A consultation request may be faxed to the physician to expedite the process. The request should be specific, concise, and directly to the point; therefore, a consultation form may be used to standardize and simplify the written request and physician's reply. All consultation requests should clearly indicate the following:
   a. Medical condition or disease of concern
   b. An explanation of the planned dental treatment and the likely systemic consequences
   c. A request for additional information and/or the physician's professional opinion
   d. The patient's signature authorizing the release of information; the dentist's signature; and the dental office's address, phone number, and fax number
   e. ***Preferably, the consult form should be in triplicate.*** One copy of the form is kept in the patient's chart, one copy is given to the patient for his or her records, and one is sent or faxed to the physician.

2. **Explain Planned Treatment.** When consulting with a physician, it is important to remember that the physician is a medical expert who may have little or no knowledge regarding dental treatment procedures and how these procedures may relate to the patient's systemic health. The use of dental terminology or jargon should be avoided when explaining the planned dental treatment.
3. **Outline Procedures.** When explaining the planned dental treatment to the physician, it is important to outline the procedures planned; length of time for each appointment; what surgical procedures will be done—including periodontal instrumentation; the amount of anticipated blood loss; possible complications, if any; and medications or anesthetics that will be used.
4. **Obtain Patient Consent.** Before contacting a patient's physician, the ***patient must grant written consent*** for the physician to release information about the patient's medical findings.
5. **Meet Legal Requirements.** Telephone consultations are not acceptable from a legal standpoint. If a consultation is conducted by telephone, request that the physician provide the information in writing by mail or fax.

When consulting with a physician, it is important to remember that the physician is a medical expert who may have little or no knowledge regarding dental treatment procedures and how these procedures may relate to the patient's systemic health.

Medical Consultation Request

To Dr: SAMUEL SNEED
620 MARKET STREET
ASHEVILLE, NC 28801

RE: MR. ALAN ASCARI
46 MAILSTRUM DRIVE
ARDEN, NC 28751

Date of Birth: _____

Date 2/05/XX

Please complete the form below and return to:
Dr: MARK STEWART, DMD
1625 POPLAR DRIVE, SUITE 10
ASHEVILLE, NC 28801

Phone: (828) 555-9856
Fax #: (828) 555-9854

Dear Dr: SNEED

The above named patient has presented with the following medical problem(s): _____

_____

_____ Adrenal insufficiency or steroid therapy
_____ Anemia
_____ Anticoagulant therapy
_____ Bleeding disorder
_____ Cardiovascular disease
_____ Chemotherapy
X Diabetes
_____ Drug allergies
_____ Endocarditis
_____ Heart murmur
_____ Hepatitis
_____ HIV
_____ Hypertension
_____ Liver disease
_____ Leukemia
_____ Mitral valve prolapse
_____ Pacemaker
_____ Prescription diet drugs
_____ Prosthetic heart valve
_____ Prosthetic joint
_____ Pulmonary disease
_____ Radiation therapy to head/neck
_____ Renal dialysis with shunts
_____ Renal disease
_____ Rheumatic heart disease
_____ Systemic lupus erythematosus
_____ Systemic-pulmonary artery shunt
_____ Other: _____

Treatment to be performed on this patient includes:

X Oral surgical procedures
_____ Extractions
_____ Endodontic treatment (root canal)
_____ Deep scaling (with some removal of epithelial tissue)
_____ Dental radiographs (x-rays)
_____ Use of magnetostrictive ultrasonic devices
_____ Local anesthesia obtained with 2% Lidocaine, 1:100,000 epinephrine
X Local anesthesia epinephrine concentration may be increased to 1:50,0000 for hemostasis, but will NOT exceed 0.2mg total

Most patients experience the following with the above planned procedures:

_____ Minimal bleeding with transient bacteria
X Prolonged bleeding
_____ Stress and anxiety: ___ Low X Moderate ___ High
_____ Other: _____
X Appointment length: 2 HOURS
X Number and frequency of appointments: 2 APPOINTMENTS AT 1 WEEK INTERVALS

Dr. Mark Stewart
Dentist's Signature

2/05/XX
Date

FIGURE 5-5A Sample medical consultation request, page 1. This form shows an example of page 1 of a completed medical consultant request for fictitious patient, Alan Ascari. Page 2 of this request form is shown on the next page.

Medical Consultation Request, page 2

I agree to the release of my medical information to: DR. MARK STEWART

Alan Ascari
Patient's Signature

2/05/XX
Date

PHYSICIAN'S RESPONSE

Please provide any information regarding the above patient's:

- **Need for antibiotic prophylaxis**
- **Current cardiovascular condition**
- **Coagulation therapy**
- **History and status of infectious disease**

CHECK ALL THAT APPLY:

_____ OK to **PROCEED** with dental treatment with **NO** special precautions and **NO** prophylactic antibiotics.

_____ Antibiotic prophylaxis **IS** required for dental treatment according to the American Heart Association and/or the American Academy of Orthopedic Surgeons guidelines.

_____ **OTHER PRECAUTIONS** are required (please list): _____

_____

_____

_____ **DO NOT PROCEED** with dental treatment (please provide reason): _____

_____

_____

_____ **DELAY** treatment until this date: _____ (please provide reason): _____

_____

_____

_____ Patient **HAS** infectious disease (please circle):

AIDS (please provide current lab results)
TB (PPD+/active)
Hepatitis, Type _____ (acute / carrier)
Other (explain): _____

_____

_____ Relevant medical and/or laboratory information is attached.

_____
Physician's Signature

_____
Date

FIGURE 5-5B Sample medical consultation request, page 2. The second page of a sample medical consultation form shows the patient's signature giving his physician permission to release medical information to the dental office. The remainder of the form is for the physician's response.

SECTION 3 • Informed Consent and the Medical History

The core value of "Individual Autonomy and Respect for Human Beings" within the Code of Ethics for the American Dental Hygienists' Association (ADHA) discusses informed consent.[11] According to this core value, "People . . . have the right to full disclosure of all relevant information so they can make informed choices about their care."

1. **Informed Consent for Patient Assessment**
   a. It is the responsibility of the dental hygienist to provide complete and comprehensive information about patient assessment procedures and planned dental hygiene treatments so that the patient can make a well-informed decision about either accepting or rejecting the proposed treatment.
   b. **Informed consent** not only involves informing the patient about the expected successful outcomes of assessment procedures but the possible risks, unanticipated outcomes and alternative treatments as well. The patient also should be made aware of the costs for each of the options involved, which may influence the patient's ultimate decision.
2. **Capacity for Consent.** A patient must also have the capacity to consent.
   a. **Capacity for consent**—the ability of a patient to fully understand the proposed treatment, possible risks, unanticipated outcomes, and alternative treatments—takes into account the patient's age, mental capacity, and language comprehension.
   b. A dialogue between the patient and the hygienist is the best way to initiate the informed consent process.
3. **Informed Refusal.** Despite being informed of the proposed treatments, risks, and alternatives, the patient may decide to refuse one or more of the recommended assessment procedures. This is called "**informed refusal**."
   a. Autonomy, as defined by the ADHA Code of Ethics, guarantees "self-determination" of the patient and is linked to informed consent.[11]
   b. Only after the patient has received informed consent can a decision be made to either accept or reject the proposed treatment. Radiographs, fluoride treatments, and sealants are a few of the dental services for which patients have exercised informed refusal.
   c. Although refusal may not be the optimal choice of the treating hygienist, the patient has a right to make any decision about his or her treatments that only affects him or her personally and does not pose a threat to others.
   d. In the case of *Erickson v. Dilgard*, the patient's right of refusal of a blood transfusion was upheld by the court despite the possibility of causing the patient's death (*Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S. 2d 705 [Sup. Ct., 1962]). Patients may refuse treatment for a number of reasons including religious beliefs, fear, or simply impulse. Proceeding with a treatment that has been refused by a patient can subject the clinician to liability for assault (causing fear) and/or battery (unconsented touching).
4. **Patient Responsibilities**
   a. The patient also has responsibilities and duties when receiving oral health care. One duty is to provide accurate responses on the medical history assessment regarding his or her current health status.
      1. In a case in Newfoundland, Canada, the judge stated that " . . . a patient has a duty to herself to do everything reasonably necessary to ensure she is properly diagnosed . . . As part of that duty, the patient must disclose all relevant and pertinent information in order to permit . . . a proper diagnosis of her medical condition."[12]

2. Simply stated, the practitioner and patient relationship is a "two-way street." A practitioner should attempt to put the patient at ease when filling out a medical history, so the patient is comfortable revealing the most private of medical details.

b. For some patients, the obstacles of comprehending the medical history questions prevent them from filling out the forms completely. For others, there may be embarrassment in being truthful, and fear of being judged or refused treatment.

c. Other patients may ask about the necessity of filling out such a comprehensive medical history assessment when "I only want my teeth cleaned." All patients must be made aware of the link between systemic and oral health, as noted in the text, and the importance of an accurate medical history in order for the practitioner to provide optimal treatment. Box 5-3 provides an example of how a clinician might respond to a patient's questions about why it is necessary to fill out a comprehensive medical history in the dental office.

BOX 5-3

Sample Explanation on the Importance of a Medical History

It is extremely important for you to fill out a complete and accurate medical history today. The decision about what treatments are best for you cannot be decided unless Dr. _____ is aware of all of your medical conditions and medications/supplements that you take. This information is needed to protect your health and, in turn, not cause you harm.

Some medical conditions require premedication, such as an antibiotic, before dental treatment. Some medical conditions may cause you to have a poor outcome of a proposed dental treatment. Some materials/drugs used in dentistry may conflict with medications you are presently taking and/or cause an adverse reaction. It is impossible to know how you are going to react to a given dental treatment if we are unaware of your total physical, mental, and dental health. By taking the time to fill out comprehensive medical history, you can help Dr. _____ decide which dental treatments are optimal and designed specifically for you, without the possible risks of medical or dental complications.

It is also important that your medical history be reviewed at each appointment to account for any changes since your last visit. Even if you were in a week before, you could have started a new medication or had a medical procedure that could influence your dental treatment.

You and the dental team assume equal roles in your overall dental care. Your role is to provide correct medical information so that the dental team can, in turn, provide dental treatment individually designed for your dental care needs.

SECTION 4 • Conducting a Medical History Assessment

To conduct a thorough medical history assessment, the dental health care provider must have a methodical plan for information gathering and review. The plan should prevent oversights or omissions of important information about the patient's medical history. This section describes a methodical plan for conducting the thorough medical history assessment required for safe patient treatment. The main steps in conducting a medical history assessment are (1) information gathering and (2) determination of medical risk.

The goal of the medical history assessment is to obtain complete information about the patient's past and present history of medical conditions and diseases, including prescription and over-the-counter medications. One successful approach for obtaining information is to combine the use of a written questionnaire to be completed by the patient with an interview of the patient. The interview provides an opportunity to clarify information and ask follow-up questions about information on the written questionnaire.

Information Gathering

The **information-gathering phase** of patient's medical history involves:

- **Reading thoroughly.** Carefully read every line and every check box on the history form completed by the patient.
- **Prioritizing.** Determine if the patient is in pain. If the patient is in pain, remember that alleviating pain takes precedence over other dental treatment.
- **Researching conditions.** Research medical conditions and diseases.
- **Researching drugs.** Research medications—prescription and over-the-counter.
- **Formulating questions.** Formulate questions to ask the patient during the medical history interview.
- **Interviewing.** After a thorough review of the health history form, the clinician should interview the patient. In order to acquire a comprehensive picture of the patient's health and medications, the clinician asks questions to clarify information on the form and to obtain additional information.
- **Consulting.** Determine the need for consultation with a physician or other health specialist.

Medical Alert Box

Medical conditions/diseases or medications that necessitate modifications or special precautions should be clearly marked in a **medical alert box** on the patient record (Box 5-4).

BOX 5-4 Contents of Medical Alert Box

- Any medical condition or disease that will alter dental treatment
- Any medical condition or disease that will alter drugs used during dental treatment or prescribed for the patient to treat dental conditions
- Any medical condition or disease that places the patient at risk for medical emergency during dental treatment
- Any medical condition or disease that could result in a postoperative complication

Stress Reduction Protocol for Anxious Patients

For certain individuals, an upcoming dental appointment causes considerable anxiety and stress. For anxious patients, stress reduction strategies are recommended (Box 5-5).

BOX 5-5

Strategies for Stress Reduction

- **Good communication.** Use empathy and effective communication to establish trust and determine the cause(s) of the patient's anxiety.
- **Reduce anxiety.** Premedicate as needed with an antianxiety medication for use (1) the night before the appointment to aid the patient in getting a good night's sleep and (2) the day of the appointment.
- **Scheduling.** Schedule appointments early in the day (so that patient will not have all day to worry about the upcoming treatment).
- **Suggestions for patient.** Suggest that the patient eat a normal meal before the appointment and allow ample travel time to get to the dental office or clinic.
- **Length of treatment.** Keep appointments short.
- **Pain control.** Ensure good pain control before, during, and after the appointment, as appropriate, including the use of pain medications and local anesthesia.

SECTION 5 • Peak Procedure

Procedure 5-1. Review of Written Questionnaire and Patient Interview

Action	Rationale
1. Read through every line and check box. Are all the questions answered?	• Complete information is important to protect the patient's health.
2. Can you understand what is written?	• Make a note to ask the patient about anything that is not clear.
3. Did the patient sign and date the form?	• The history must be signed and dated.
4. Circle **YES** responses in red pencil.	• YES answers should be discussed during the interview.
5. Read through handwritten responses made by the patient. Circle concerns in red pencil.	• Discuss concerns during the interview.
6. Research medical conditions and diseases including: **a.** Definition **b.** Symptoms or manifestations **c.** Treatments and medications **d.** Systemic side effects that may necessitate treatment modifications **e.** Oral manifestations **f.** Impact on dental care	• This is basic data that will be used to formulate questions for the patient and to determine if dental care involves any risks for the patient. Common medical conditions and diseases may be researched by using the Ready References found in Module 6.
7. Identify risks to the patient's overall health, such as poorly controlled diabetes, obesity, periodontal disease, and tobacco use. Identify systemic factors that increase the risk of periodontal disease, such as tobacco use, poorly controlled diabetes, hormone alterations, psychosocial stress, and medications. **Circle concerns in red pencil.**	• Dental health care providers should identify systemic health risks and promote wellness. • There is a connection between periodontitis and systemic health. Periodontal infection may contribute to the development of heart disease, premature/underweight babies, poorly controlled diabetes, and respiratory diseases. • Dental health care providers should be alert for systemic factors that may increase the risk of developing periodontal disease.

Procedure 5-1. Review of Written Questionnaire and Patient Interview, continued

Action	Rationale
8. Research the patient's medications, prescribed and nonprescription, including: **a.** Drug use **b.** Systemic side effects **c.** Oral side effects **d.** Dental treatment modifications or concerns Medications can be researched on the Internet, in drug reference books, and using the Ready References found in Module 6 of this book.	• It is important to determine why each medication is being taken. • Some patients are not knowledgeable about their medical conditions. In such cases, medications can be a valuable clue to the patient's health status. • Many medications have systemic side effects that may necessitate modifications to dental treatment. For example, many medications cause dizziness or orthostatic hypotension, thus indicating that the clinician should adjust the chair position slowly. • Other medications have side effects that can alter a patient's dental health. Xerostomia, gingival overgrowth, and gingival bleeding are examples of oral side effects. • Some medications dictate modifications or precautions before, during, or after to dental treatment. For example, a blood thinning medication reduces the ability of the blood to clot.
9. Ask the patient questions about his or her medical conditions or diseases. **a. Duration**—When was the condition first diagnosed? **b. Treatments and Procedures**—What is being done to treat the condition? **c. Episodes**—What brings on the condition? What changes the severity?	• This factual information is important in determining if the patient can be treated safely. • Certain medical conditions and diseases have oral manifestations. • Certain medical conditions affect the health of the periodontium.
10. Ask the patient questions about the medications, prescription and over-the-counter, as well as any herbal/vitamin supplements that he or she is taking. **a.** How long? Date started and ended **b.** How much? Dosage	• This factual information is important in determining if the patient can be treated safely. • Certain medical conditions and diseases have oral manifestations.

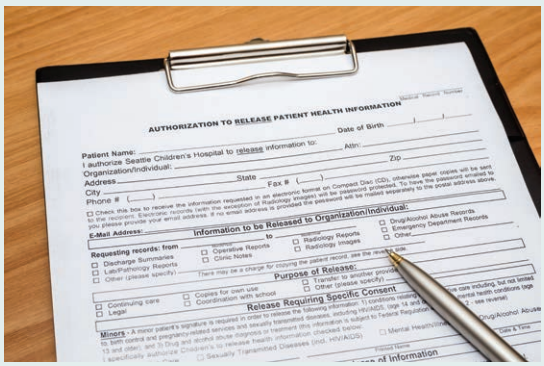
NOTE: The next chapter, **Module 6: Ready References: Medical History**, contains two Ready References designed to provide fast access to commonly encountered medical conditions and medications.

- Ready Reference 6-1. Common Conditions of Concern in Dentistry
- Ready Reference 6-2. Commonly Prescribed Drugs

SECTION 6 • The Human Element

Through the Eyes of Clinicians and Patients

A COMPLICATED MEDICAL HISTORY



It was my third week of clinic, and I was feeling quite confident about medical history assessments. I started thinking that the lecture we had in clinic theory on assessing medical histories was very unrealistic. The example the instructor gave us was a patient on seven different drugs and three different diseases.

Well today was the day! The health history form seemed to have as many questions checked in the "Yes" column as the "No" column. I started to panic, thinking that it was going to take me all day to review the medical history and that the patient would be upset with me for taking so long. The patient was overweight and had diabetes, high blood pressure, and high cholesterol. She checked "Yes" to chest pain on exertion, sleep disorder, and being out of breath. Her medications included several cardiac drugs as well as insulin.

I began looking things up in a reference book when my instructor looked over my shoulder and asked me if I had ever heard of "metabolic syndrome." I looked it up in a reference book. Suddenly, all the "Yes" questions made sense. I felt I had a handle on the patient's overall condition. That confidence allowed me to readily gather the rest of the information, link it together, and conduct the patient interview. It turned out to be a great appointment. My patient was so nice, and I learned a lot about her and her health history.

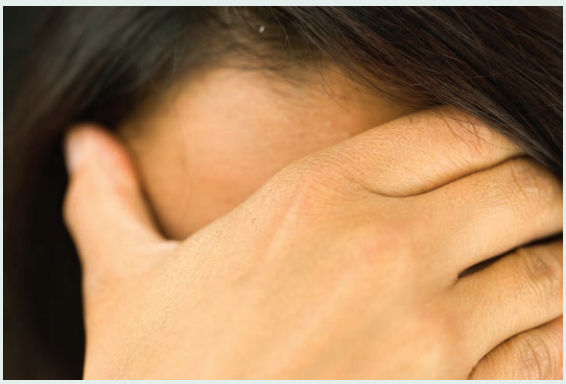
Stephanie, student,
Tallahassee Community College

SATISFACTION WITH DENTAL CARE

Interview someone who has recently received dental hygiene care in a dental office. Using open-ended questions, encourage the person to relate his or her experiences as a dental patient receiving care from a dental hygienist. Listen for what this person perceived as positive and supportive or negative and nonsupportive about the care provided by the hygienist. Reflect on the person's experience and write a paragraph or participate in a group discussion on how this information will impact how you provide care as a dental hygienist.

MEDICAL HISTORIES MAY ELICIT SENSITIVE INFORMATION

Generate a list of topics you would find embarrassing to discuss with patients when gathering information during the medical history assessment. For example, when inquiring about recent hospitalizations or current medications, would you feel uncomfortable if the patient shared that she was hospitalized 2 months ago after a miscarriage; or a patient that shares that he is taking a medication for a sexually transmitted disease? With other students, generate a list of potentially embarrassing topics (for the clinician and/or the patient) and discuss potential strategies to approach these topics and manage embarrassment.



Ethical Dilemma

CAN A 17-YEAR-OLD CONSENT TO TREATMENT?

Your last patient of the morning is Sandy L., a 17-year-old who is new to the dental practice. Her mother is sitting with Sandy in the waiting room, helping her fill out her medical history assessment. You call Sandy into your operatory. Her mother tells you that she will wait for Sandy and would like to speak to the dentist before she is discharged today.

You begin reviewing Sandy's medical history with her, which appears uneventful. After you complete her extra- and intraoral exam, you discuss with Sandy the office policy of taking radiographs on new patients. Sandy states that she has not had any x-rays in a few years and agrees. As you are about to place the first radiograph in her mouth, Sandy begins to cry. Assuming she has fear of the dental office, you stop and try to comfort her. Sandy states that she has no fear but suspects that she may be pregnant and has heard that radiation "could harm the baby." Sandy pleads with you not to tell anyone, especially her mother.

1. What is the best way for you to handle this ethical dilemma?
2. Can a 17-year-old consent to treatment or must you receive parental consent?
3. Under the ethical principle of confidentiality, can you discuss this with your employer dentist, without violating Sandy's confidentiality?
4. Do you have the right to divulge Sandy's pregnancy to her mother?

English-to-Spanish Phrase Lists

USING THE ENGLISH-TO-SPANISH PHRASE LISTS

According to the United States Census Bureau, more than one-half of the 2002 foreign-born residents in the United States were born in Latin America. Communication problems can occur when an English-speaking clinician tries to communicate with a patient who is not fluent in English.

- Teaching student clinicians to pronounce and speak Spanish is well beyond the scope of this book and, indeed, of most professional curriculums.
- For those times when a trained medical translator is not available, the modules in this textbook include English-to-Spanish phrase lists with phrases pertinent to the assessment process. The first of these phrase lists is found in Table 5-2 on the following page.
- To use these phrase lists, the student clinician simply points to a specific phrase in the patient's native language to facilitate communication.

TABLE 5-2 ENGLISH-TO-SPANISH PHRASE LIST FOR MEDICAL HISTORY ASSESSMENT

Good morning (afternoon), Mr. _____.	Buenos días (tardes), señor _____.
Good morning (afternoon), Mrs. _____.	Buenos días (tardes), señora _____.
Good morning (afternoon), Miss _____.	Buenos días (tardes) señorita _____.
My name is ____. I am your dental hygienist.	Me llama _____. Soy su higienista dental.
It is nice to meet you.	Mucho gusto en conocerlo (conocerla)
I do not speak Spanish; I will point to Spanish phrases.	No hablo español; Voy ha indicar Las frases en español.
Please follow me to the dental chair.	Por favor siga me a la silla dental.
Please turn to the right.	Por favor valla a la derecha.
Please turn to the left.	Por favor valla a la izquierda.
Please sit here in this chair.	Por favor siente se en esta silla.
You forgot to answer this question.	Se olvido responder esta pregunta.
Do you have your medications with you?	¿Tiene sus medicinas con usted?
Please bring your medications with you for your next appointment.	Por favor traiga sus medicinas con usted a su próximo cita.
Why do you take these medications?	¿Por que tome usted estos medicamentos?
Please sign here.	Por favor firme aquí.
We cannot do dental treatment until we consult with your doctor.	No podemos hacer un tratamiento hasta que consultemos con su doctor.
Wait here, I will get the dentist or instructor.	Espere aquí; voy a buscar el dentista o el profesor.
We are finished for today.	Hemos terminarlos por hoy.
We will schedule your next appointment.	Vamos hacer una nueva cita.
Goodbye, see you next time.	Hasta luego; La (Lo) veremos la próxima cita.

SECTION 7 • Practical Focus—Fictitious Patient Cases

This section contains the medical history and medication list for five fictitious patients, patients A to E. In addition, **Health History Interview** and **Medical Consultation Request** forms are provided for patients A to E (Figs. 5-6 to 5-25).

DIRECTIONS

- Remove the forms for patients A to E from the book for ease of use.
- For each patient, follow the steps outlined below to conduct an assessment of the medical history and medications.

1. **Review Medical History**
   - Carefully read the patient's completed medical history form.
   - Circle all "Yes" answers in red.
   - Circle any unanswered questions.
2. **Research Medical Conditions and Diseases**
   - Research all medical conditions and diseases.
   - Start by locating the **Ready Reference 6-1. Common Conditions of Concern in Dentistry** located in **Module 6** of this book.
   - As needed, conduct additional research. If a computer connected to the Internet is available, go online to locate additional information. If you do not have a computer, use oral medicine books to do additional research.
3. **Research Medications—Prescription and Over-the-Counter**
   - Research all medications.
   - Start by using **Ready Reference 6-2. Commonly Prescribed Drugs** located in **Module 6** of this book.
   - As needed, conduct additional research either on the Internet or using drug reference books.
4. **Summarize Information and Formulate Questions**
   - Complete the **Health History Interview** form for each patient.
   - At this point—after reviewing the patient's medical history, medications, and doing your research—do you have concerns about treating the patient?
   - Do you think any modifications will need to be made in order to treat this patient safely?
   - Make a list of follow-up questions that you should ask during the patient interview. Write your questions on page 2 of the **Health History Interview** form.
5. **Determine if a Medical Consultation Is Needed**
   - For each patient, assess the need for a medical consultation. If needed, complete **page 1 of the Medical Consultation Request**.

MetLife University of the Pacific

HEALTH HISTORY - English

Patient Name: Ascari, Alan A. Patient Identification Number: A-546390

Birth Date: 70 years

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand question):

1. (Yes) No Is your general health good?
2. Yes (No) Has there been a change in your health within the last year?
3. (Yes) No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? too little insulin
4. (Yes) No Are you being treated by a physician now? For what? diabetes
   Date of last medical exam? 6 months Date of last dental exam? about 5 years ago
5. Yes (No) Have you had problems with prior dental treatment?
6. Yes (No) Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes (No)	Chest pain (angina)?	18. Yes	(No)	Dizziness?
8.	Yes (No)	Swollen ankles?	19. Yes	(No)	Ringing in ears?
9.	Yes (No)	Shortness of breath?	20. Yes	(No)	Headaches?
10.	(Yes) No	Recent weight loss, fever, night sweats?	21. Yes	(No)	Fainting spells?
11.	Yes (No)	Persistent cough, coughing up blood?	22. Yes	(No)	Blurred vision?
12.	Yes (No)	Bleeding problems, bruising easily?	23. Yes	(No)	Seizures?
13.	Yes (No)	Sinus problems?	24. Yes	(No)	Excessive thirst?
14.	Yes (No)	Difficulty swallowing?	25. Yes	(No)	Frequent urination?
15.	Yes (No)	Diarrhea, constipation, blood in stools?	26. (Yes)	No	Dry mouth?
16.	Yes (No)	Frequent vomiting, nausea?	27. Yes	(No)	Jaundice?
17.	Yes (No)	Difficulty urinating, blood in urine?	28. (Yes)	No	Joint pain?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes (No)	Heart disease?	40. Yes	(No)	AIDS?
30.	Yes (No)	Heart attack, heart defects?	41. Yes	(No)	Tumors, cancer?
31.	Yes (No)	Heart murmurs?	42. Yes	(No)	Arthritis, rheumatism?
32.	Yes (No)	Rheumatic fever?	43. Yes	(No)	Eye diseases?
33.	Yes (No)	Stroke, hardening of arteries?	44. Yes	(No)	Skin diseases?
34.	Yes (No)	High blood pressure?	45. Yes	(No)	Anemia?
35.	Yes (No)	Asthma, TB, emphysema, other lung disease?	46. Yes	(No)	VD (syphilis or gonorrhea)?
36.	Yes (No)	Hepatitis, other liver disease?	47. Yes	(No)	Herpes?
37.	Yes (No)	Stomach problems, ulcers?	48. Yes	(No)	Kidney, bladder disease?
38.	Yes (No)	Allergies to: drugs, foods, medications, latex?	49. Yes	(No)	Thyroid, adrenal disease?
39.	Yes (No)	Family history of diabetes, heart problems, tumors?	50. (Yes)	No	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes (No)	Psychiatric care?	56. Yes	(No)	Hospitalization?
52.	Yes (No)	Radiation treatments?	57. Yes	(No)	Blood transfusions?
53.	Yes (No)	Chemotherapy?	58. Yes	(No)	Surgeries?
54.	Yes (No)	Prosthetic heart valve?	59. Yes	(No)	Pacemaker?
55.	Yes (No)	Artificial joint?	60. Yes	(No)	Contact lenses?

V. ARE YOU TAKING:

61.	Yes (No)	Recreational drugs?	63. (Yes)	No	Tobacco in any form? Smoke 2 packs a day
62.	(Yes) No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64. Yes	(No)	Alcohol?

Please list: See Medication List

VI. WOMEN ONLY:

65.	Yes (No)	Are you or could you be pregnant or nursing?	63. Yes	(No)	Taking birth control pills?

VII. ALL PATIENTS:

64. (Yes) No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: teeth very sensitive to cold drinks and ice cream; dry mouth

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: Alan A. Ascari Date: 1-15-20XX

RECALL REVIEW:

1. Patient's signature: _____ Date: _____
2. Patient's signature: _____ Date: _____
3. Patient's signature: _____ Date: _____

The Health History is created and maintained by the University of Pacific School of Dentistry, San Francisco, California.
Support for the translation and dissemination of the Health Histories comes from MetLife Dental Care.

FIGURE 5-6 The health history form for fictitious patient Mr. Ascari.

Medication List

Patient ALAN ASCARI Date 1/15/XX

PRESCRIBED

HUMULIN R: ONE INJECTION TWICE A DAY

OVER-THE-COUNTER

DAYQUIL LIQUICAP
NYQUIL

VITAMINS, HERBS, DIET SUPPLEMENTS

CHROMIUM 100 MCG PER D
ALPHA LIPOIC ACID 200 MG PER DAY

FIGURE 5-7 **Medication list for fictitious patient Mr. Ascari.**

Health History Interview: PART 1

Patient Name: Ascari, Alan A.

Directions: Record the number and details of any YES answer noted on the Health History.

Number	Significant Medical Findings	Dental Management Considerations

Medications	Dental Management Considerations

Date _____ Student Clinician Signature _____ Instructor Signature _____

FIGURE 5-8A **Mr. Ascari: health history synopsis part 1.**

Health History Interview: PART 2

Patient Name: Ascari, Alan A.

Additional Information or Consultations
Directions: List any additional information that should be obtained before dental treatment begins.

Questions for Patient Interview
Directions: Formulate a list of questions for the patient interview.

FIGURE 5-8B **Mr. Ascari: health history synopsis part 2.**

Medical Consultation Request

To Dr: _____

_____

_____

RE: _____

_____

_____

Date of Birth: _____

Date _____

Please complete the form below and return to:

Dr: _____

_____

_____

Phone: _____

Fax #: _____

Dear Dr: _____

The above named patient has presented with the following medical problem(s): _____

_____

_____ Adrenal insufficiency or steroid therapy
_____ Anemia
_____ Anticoagulant therapy
_____ Bleeding disorder
_____ Cardiovascular disease
_____ Chemotherapy
_____ Diabetes
_____ Drug allergies
_____ Endocarditis
_____ Heart murmur
_____ Hepatitis
_____ HIV
_____ Hypertension
_____ Liver disease
_____ Leukemia
_____ Mitral valve prolapse
_____ Pacemaker
_____ Prescription diet drugs
_____ Prosthetic heart valve
_____ Prosthetic joint
_____ Pulmonary disease
_____ Radiation therapy to head/neck
_____ Renal dialysis with shunts
_____ Renal disease
_____ Rheumatic heart disease
_____ Systemic lupus erythematosus
_____ Systemic-pulmonary artery shunt
_____ Other: _____

Treatment to be performed on this patient includes:

_____ Oral surgical procedures
_____ Extractions
_____ Endodontic treatment (root canal)
_____ Deep scaling (with some removal of epithelial tissue)
_____ Dental radiographs (x-rays)
_____ Use of magnetostrictive ultrasonic devices
_____ Local anesthesia obtained with 2% Lidocaine, 1:100,000 epinephrine
_____ Local anesthesia epinephrine concentration may be increased to 1:50,0000 for hemostasis, but will NOT exceed 0.2mg total

Most patients experience the following with the above planned procedures:

_____ Minimal bleeding with transient bacteria
_____ Prolonged bleeding
_____ Stress and anxiety: ___ Low ___ Moderate ___ High
_____ Other: _____
_____ Appointment length: _____
_____ Number and frequency of appointments: _____
_____
_____

_____
Dentist's Signature

_____
Date

FIGURE 5-9 **Page 1 of medical consultation request for Mr. Ascari (if needed).**

HEALTH HISTORY - Children's

Name of Child: Biddle, (Last) Bethany (First) B. (Middle)

Birth Date: Age 9 Child's Gender: M (F)

Custodial Parent's or Guardian's Name: Brenda Biddle Relationship to Child: Mother

Address: 311 First Avenue, Hendersonville (City:) NC (State:) 28777 (Zip Code:)

Phone Numbers: (828) 555-6153 (Home:) (828) 555-4367 (Work:) (828) 555-8707 (Cell:)

Name and Phone Number for the Child's Physician: Dr. Mary Mercer (828) 555-2345

I. DOES THE CHILD HAVE OR HAS THE CHILD HAD ANY OF THE CONDITIONS/DISEASES BELOW?

1.	Yes	(No)	Anemia?	11.	Yes	(No)	Hepatitis?
2.	(Yes)	No	Asthma or Breathing Problems? Asthma	12.	Yes	(No)	HIV/AIDS?
3.	Yes	(No)	Arthritis or Joint Problems?	13.	Yes	(No)	Hyperactivity Disorder?
4.	Yes	(No)	Attention Disorder?	14.	Yes	(No)	Kidney or Liver Problems?
5.	Yes	(No)	Bleeding or Clotting Disorder?	15.	Yes	(No)	Mononucleosis?
6.	Yes	(No)	Cancer or Chemotherapy?	16.	Yes	(No)	Persistent Cough or Coughing up Blood?
7.	Yes	(No)	Diabetes?				
8.	Yes	(No)	Fainting Spells?	17.	Yes	(No)	Rheumatic Fever?
9.	Yes	(No)	Ear or Hearing Problems?	18.	Yes	(No)	Seizures or Epilepsy?
10.	Yes	(No)	Heart Defect or Problems?	19.	Yes	(No)	Tuberculosis?

II. FOR EACH ITEM BELOW LIST THE INFORMATION REQUIESTED FOR THE CHILD:

Allergies/Sensitivities to Medications, Food, or other Substances:
Please list: latex (hives and breathing difficulty); penicillin; bananas; seafood

Concerns about Social or Developmental needs:
Please list: none

Current Immunizations:
Please list: meningitis; pneumonia, hepatitis A and B; polio, measles, mumps, rubella, varicella, flu

Hospitalizations:
Please list: 6 months ago for severe asthma attacks

Inherited Problems:
Please list: none

Serious Injuries:
Please list: none

Over-the-Counter Medications or Supplements being taken:
Please list: see Medication List

Prescription Medications being taken:
Please list: see Medication List

Vitamins, Herbs, or Diet Supplements being taken:
Please list: see Medication List

Has the Child had or does the Child have any diseases or conditions not already listed on this form? Yes (No)

If yes, please explain:

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Parent's or Guardian's signature: Brenda Biddle Date: 1-10-20XX

FIGURE 5-10 **Health history form for fictitious patient Bethany Biddle.**

Medication List

Patient BETHANY BIDDLE Date 1/10/XX

PRESCRIBED

FLOVENT ROTADISK 50MCG: 1 INHALATION TWICE A DAY
SEREVENT DISCUS: 1 INHALATION TWICE A DAY
ZYRTEC CHEWABLE TABLETS: 5MG THREE TIMES A DAY
VENTOLIN INHALER, WHEN NEEDED FOR ATTACK

OVER-THE-COUNTER

VITAMINS, HERBS, DIET SUPPLEMENTS

FLINTSTONES MULTIVITAMINS

FIGURE 5-11 **Medication list for fictitious patient Bethany Biddle.**

Health History Interview: PART 1

Patient Name: Biddle, Bethany B.

Directions: Record the number and details of any YES answer noted on the Health History.

Number	Significant Medical Findings	Dental Management Considerations

Medications	Dental Management Considerations

Date _____ Student Clinician Signature _____ Instructor Signature _____

FIGURE 5-12A **Bethany Biddle: health history synopsis part 1.**

Health History Interview: PART 2

Patient Name: Biddle, Bethany B.

Additional Information or Consultations
Directions: List any additional information that should be obtained before dental treatment begins.

Questions for Patient Interview
Directions: Formulate a list of questions for the patient interview.

FIGURE 5-12B **Bethany Biddle: health history synopsis part 2.**

Medical Consultation Request

To Dr: _____

_____

_____

RE: _____

_____

_____

Date of Birth: _____

Date _____

Please complete the form below and return to:

Dr: _____

_____

_____

Phone: _____

Fax #: _____

Dear Dr: _____

The above named patient has presented with the following medical problem(s): _____

_____

_____ Adrenal insufficiency or steroid therapy
_____ Anemia
_____ Anticoagulant therapy
_____ Bleeding disorder
_____ Cardiovascular disease
_____ Chemotherapy
_____ Diabetes
_____ Drug allergies
_____ Endocarditis
_____ Heart murmur
_____ Hepatitis
_____ HIV
_____ Hypertension
_____ Liver disease
_____ Leukemia
_____ Mitral valve prolapse
_____ Pacemaker
_____ Prescription diet drugs
_____ Prosthetic heart valve
_____ Prosthetic joint
_____ Pulmonary disease
_____ Radiation therapy to head/neck
_____ Renal dialysis with shunts
_____ Renal disease
_____ Rheumatic heart disease
_____ Systemic lupus erythematosus
_____ Systemic-pulmonary artery shunt
_____ Other: _____

Treatment to be performed on this patient includes:

_____ Oral surgical procedures
_____ Extractions
_____ Endodontic treatment (root canal)
_____ Deep scaling (with some removal of epithelial tissue)
_____ Dental radiographs (x-rays)
_____ Use of magnetostrictive ultrasonic devices
_____ Local anesthesia obtained with 2% Lidocaine, 1:100,000 epinephrine
_____ Local anesthesia epinephrine concentration may be increased to 1:50,0000 for hemostasis, but will NOT exceed 0.2mg total

Most patients experience the following with the above planned procedures:

_____ Minimal bleeding with transient bacteria
_____ Prolonged bleeding
_____ Stress and anxiety: ___ Low ___ Moderate ___ High
_____ Other: _____
_____ Appointment length: _____
_____ Number and frequency of appointments: _____
_____
_____

_____
Dentist's Signature

_____
Date

FIGURE 5-13 **Page 1 of medical consultation request for Bethany Biddle (if needed).**

MetLife University of the Pacific

HISTORIA MÉDICA - Spanish

Nombre del paciente: Chavez, Carlos C. No. de Ident. del Paciente: C-093841

Fecha de nacimiento: 25 años (25 years)

I. MARQUE CON UN CÍRCULO LA RESPUESTA CORRECTA (Deje en BLANCO si no entiende la pregunta):

1. (Sí) No ¿Está en buena salud general?
2. Sí (No) ¿Han habido cambios en su salud durante el último a o?
3. Sí (No) ¿Ha estado hospitalizado/a o ha tenido de una enfermedad grave en los últimos tres años? ¿Si Sí, por qué?
4. (Sí) No ¿Se encuentra actualmente bajo tratamiento médico? ¿Para qué? Epilepsia (epilepsy)
   Fecha de su último examen médico: Hace un año (1 year ago) Fecha de su última cita dental: Hace dos años (2 years ago)
5. Sí (No) ¿Ha tenido problemas con algún tratamiento dental en el pasado?
6. Sí (No) ¿Tiene algún dolor ahora?

II. HA NOTADO:

7.	Sí	(No)	¿Dolor de pecho (angina)?	18.	Sí	(No)	¿Mareos?
8.	Sí	(No)	¿Los tobillos hinchados?	19.	Sí	(No)	¿Ruidos o zumbidos en los oídos?
9.	Sí	(No)	¿Falta de aliento?	20.	Sí	No	¿Dolores de cabeza? migranas
10.	Sí	(No)	¿Reciente pérdida de peso, fiebre, sudor en la noche?	21.	Sí	(No)	¿Desmayos?
11.	Sí	(No)	¿Tos persistente o tos con sangre?	22.	Sí	(No)	¿Vista borrosa?
12.	Sí	(No)	¿Problemas de sangramiento, moretes?	23.	Sí	No	¿Convulsiones?
13.	Sí	(No)	¿Problemas nasales (sinusitis)?	24.	Sí	(No)	¿Sed excesiva?
14.	Sí	(No)	¿Dificultad al tragar?	25.	Sí	(No)	¿Orina con frecuencia?
15.	Sí	(No)	¿Diarrea, estreñimiento, sangre en las heces?	26.	Sí	(No)	¿Boca seca?
16.	Sí	(No)	¿Vómitos con frecuencia, náuseas?	27.	Sí	(No)	¿Ictericia?
17.	Sí	(No)	¿Difucltad al orinar, sangre en la orina?	28.	Sí	(No)	¿Dolor o rigidez en las articulaciones?

III. TIENE O HA TENIDO:

29.	Sí	(No)	¿Enfermedades del corazón?	40.	Sí	(No)	¿SIDA?
30.	Sí	(No)	¿Infarto de corazón, defectos en el corazón?	41.	Sí	(No)	¿Tumores, cáncer?
31.	Sí	(No)	¿Soplos en la corazón?	42.	Sí	(No)	¿Artritis, reuma?
32.	Sí	(No)	¿Fiebre reumática?	43.	Sí	(No)	¿Enfermedades de los ojos?
33.	Sí	(No)	¿Apoplejía, endurecimiento de las arterias?	44.	Sí	(No)	¿Enfermedades de la piel?
34.	Sí	(No)	¿Presión sanguínea alta?	45.	Sí	(No)	¿Anemia?
35.	Sí	(No)	¿Asma, tuberculosis, enfisema, otras enfermedades pulmonares?	46.	Sí	(No)	¿Enfermedades venéreas (sífilis o gonorrea)?
36.	Sí	(No)	¿Hepatitis, otras enfermedades del hígado?	47.	Sí	(No)	¿Herpes?
37.	Sí	(No)	¿Problemas del estómago, úlceras?	48.	Sí	(No)	¿Enfermedades renales (riñión), vejiga?
38.	Sí	(No)	¿Alergias a remedios, comidas, medicamentos látex?	49.	Sí	(No)	¿Enfermedades de tiroides o glándulas suprarrenales?
39.	Sí	(No)	¿Familiares con diabetes, problemas de corazón, tumores?	50.	Sí	(No)	¿Diabetes?

IV. TIENE O HA TENIDO:

51.	Sí	(No)	¿Tratamiento psiquiátrico?	56.	Sí	(No)	¿Hospitalizaciones?
52.	Sí	(No)	¿Tratamientos de radiación?	57.	Sí	(No)	¿Transfusiones de sangre?
53.	Sí	(No)	¿Quimioterapia?	58.	Sí	(No)	¿Circugías?
54.	Sí	(No)	¿Válvula artificial del corazón?	59.	Sí	(No)	¿Marcapasos?
55.	Sí	(No)	¿Articulación articial?	60.	Sí	(No)	¿Lentes de contacto?

V. ESTÁ TOMANDO:

61.	Sí	(No)	¿Drogas de uso recreativo?	63.	Sí	(No)	¿Tabaco de cualquier tipo?
62.	(Sí)	No	¿Remedios, medicamentos, medicamentos sin receta (incluyendo aspirina)?	64.	(Sí)	No	¿Alcohol (bebidas alcohólicas)? 4 Cervesas (4 beers per week)

Liste por favor: Ver lista adjunta (see attached list)

VI. SÓLO PARA MUJERES:

65.	Sí	(No)	¿Está o podría estar embarazada o dando pecho?	63.	Sí	No	¿Está tomando pastillas anticonceptivas?

VII. PARA TODOS LOS PACIENTES:

64. Sí (No) ¿Tiene o ha tenido alguna otra enfermedad o problema médico que NO está en este cuestionario?

Si la respuesta es afirmativa, explique: Ulceas en la boca (ulcers in mouth)

Que yo sepa, he respondido completamente y correctamente todas las preguntas. Informaré a mi dentista si hay algún cambio en mi salud y/o en los medicamentos que tomo.

Firma del Paciente: Carlos C. Chavez Fecha: 1-15-20XX

REVISIÓN SUPLEMENTARIA:

1. Firma del Paciente: _____ Fecha: _____
2. Firma del Paciente: _____ Fecha: _____
3. Firma del Paciente: _____ Fecha: _____

The Health History is created and maintained by the University of Pacific School of Dentistry, San Francisco, California.
Support for the translation and dissemination of the Health Histories comes from MetLife Dental Care.

FIGURE 5-14 The health history form for fictitious patient Mr. Chavez.

Medication List

Patient CARLOS CHAVEZ Date 1/05/XX

PRESCRIBED

PHENYTOIN 100MG THREE TIMES A DAY

OVER-THE-COUNTER

ASPIRIN FOR STRAINED MUSCLE IN BACK

VITAMINS, HERBS, DIET SUPPLEMENTS

FIGURE 5-15 **Medication list for fictitious patient Mr. Chavez.**

Health History Interview: PART 1

Patient Name: Chavez, Carlos C.

Directions: Record the number and details of any YES answer noted on the Health History.

Number	Significant Medical Findings	Dental Management Considerations

Medications	Dental Management Considerations

Date _____ Student Clinician Signature _____ Instructor Signature _____

FIGURE 5-16A **Mr. Chavez: health history synopsis part 1.**

Health History Interview: PART 2

Patient Name: Chavez, Carlos C.

Additional Information or Consultations
Directions: List any additional information that should be obtained before dental treatment begins.

Questions for Patient Interview
Directions: Formulate a list of questions for the patient interview.

FIGURE 5-16B **Mr. Chavez: health history synopsis part 2.**

Medical Consultation Request

To Dr: _____

_____

_____

RE: _____

_____

_____

Date of Birth: _____

Date _____

Please complete the form below and return to:

Dr: _____

_____

_____

Phone: _____

Fax #: _____

Dear Dr: _____

The above named patient has presented with the following medical problem(s): _____

_____

_____ Adrenal insufficiency or steroid therapy
_____ Anemia
_____ Anticoagulant therapy
_____ Bleeding disorder
_____ Cardiovascular disease
_____ Chemotherapy
_____ Diabetes
_____ Drug allergies
_____ Endocarditis
_____ Heart murmur
_____ Hepatitis
_____ HIV
_____ Hypertension
_____ Liver disease
_____ Leukemia
_____ Mitral valve prolapse
_____ Pacemaker
_____ Prescription diet drugs
_____ Prosthetic heart valve
_____ Prosthetic joint
_____ Pulmonary disease
_____ Radiation therapy to head/neck
_____ Renal dialysis with shunts
_____ Renal disease
_____ Rheumatic heart disease
_____ Systemic lupus erythematosus
_____ Systemic-pulmonary artery shunt
_____ Other: _____

Treatment to be performed on this patient includes:

_____ Oral surgical procedures
_____ Extractions
_____ Endodontic treatment (root canal)
_____ Deep scaling (with some removal of epithelial tissue)
_____ Dental radiographs (x-rays)
_____ Use of magnetostrictive ultrasonic devices
_____ Local anesthesia obtained with 2% Lidocaine, 1:100,000 epinephrine
_____ Local anesthesia epinephrine concentration may be increased to 1:50,0000 for hemostasis, but will NOT exceed 0.2mg total

Most patients experience the following with the above planned procedures:

_____ Minimal bleeding with transient bacteria
_____ Prolonged bleeding
_____ Stress and anxiety: ___ Low ___ Moderate ___ High
_____ Other: _____
_____ Appointment length: _____
_____ Number and frequency of appointments: _____
_____
_____

_____
Dentist's Signature

_____
Date

FIGURE 5-17 Page 1 of medical consultation request for Mr. Chavez (if needed).

MetLife University of the Pacific

HEALTH HISTORY - English

Patient Name: Doi, Donna D. Patient Identification Number: D-912540

Birth Date: 27 years

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand question):

1. (Yes) No — Is your general health good?
2. Yes (No) — Has there been a change in your health within the last year?
3. Yes (No) — Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. (Yes) No — Are you being treated by a physician now? For what? 5 months pregnant with first child
   Date of last medical exam? last week Date of last dental exam? 6 months ago
5. Yes (No) — Have you had problems with prior dental treatment?
6. Yes (No) — Are you in pain now? Bleeding gums

II. HAVE YOU EXPERIENCED:

7.	Yes	(No)	Chest pain (angina)?	18.	Yes	(No)	Dizziness?
8.	Yes	(No)	Swollen ankles?	19.	Yes	(No)	Ringing in ears?
9.	Yes	(No)	Shortness of breath?	20.	(Yes)	No	Headaches? migraines
10.	Yes	(No)	Recent weight loss, fever, night sweats?	21.	Yes	(No)	Fainting spells?
11.	Yes	(No)	Persistent cough, coughing up blood?	22.	Yes	(No)	Blurred vision?
12.	Yes	(No)	Bleeding problems, bruising easily?	23.	Yes	(No)	Seizures?
13.	(Yes)	No	Sinus problems?	24.	Yes	(No)	Excessive thirst?
14.	Yes	(No)	Difficulty swallowing?	25.	Yes	(No)	Frequent urination?
15.	Yes	(No)	Diarrhea, constipation, blood in stools?	26.	Yes	(No)	Dry mouth?
16.	Yes	(No)	Frequent vomiting, nausea?	27.	Yes	(No)	Jaundice?
17.	Yes	(No)	Difficulty urinating, blood in urine?	28.	Yes	(No)	Joint pain?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	(No)	Heart disease?	40.	Yes	(No)	AIDS?
30.	Yes	(No)	Heart attack, heart defects?	41.	Yes	(No)	Tumors, cancer?
31.	Yes	(No)	Heart murmurs?	42.	Yes	(No)	Arthritis, rheumatism?
32.	Yes	(No)	Rheumatic fever?	43.	Yes	(No)	Eye diseases?
33.	Yes	(No)	Stroke, hardening of arteries?	44.	Yes	(No)	Skin diseases?
34.	Yes	(No)	High blood pressure?	45.	Yes	(No)	Anemia?
35.	Yes	(No)	Asthma, TB, emphysema, other lung disease?	46.	Yes	(No)	VD (syphilis or gonorrhea)?
36.	Yes	(No)	Hepatitis, other liver disease?	47.	Yes	(No)	Herpes?
37.	Yes	(No)	Stomach problems, ulcers?	48.	Yes	(No)	Kidney, bladder disease?
38.	(Yes)	No	Allergies to: drugs, foods, medications, latex? Aspirin, cats	49.	Yes	(No)	Thyroid, adrenal disease?
39.	Yes	(No)	Family history of diabetes, heart problems, tumors?	50.	Yes	(No)	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	(No)	Psychiatric care?	56.	(Yes)	No	Hospitalization? for knee replacement
52.	Yes	(No)	Radiation treatments?	57.	Yes	(No)	Blood transfusions?
53.	Yes	(No)	Chemotherapy?	58.	Yes	(No)	Surgeries?
54.	Yes	(No)	Prosthetic heart valve?	59.	Yes	(No)	Pacemaker?
55.	(Yes)	No	Artificial joint? knee replacement, 3 years ago	60.	Yes	(No)	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	(No)	Recreational drugs?	63.	Yes	(No)	Tobacco in any form?
62.	(Yes)	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	(No)	Alcohol?

Please list: See Medication List

VI. WOMEN ONLY:

65. (Yes) No — Are you or could you be pregnant or nursing? 63. Yes (No) — Taking birth control pills?

VII. ALL PATIENTS:

64. (Yes) No — Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain: frequent heartburn during pregnancy; hay fever

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: Donna Doi Date: 1-15-20XX

RECALL REVIEW:

1. Patient's signature: _____ Date: _____
2. Patient's signature: _____ Date: _____
3. Patient's signature: _____ Date: _____

The Health History is created and maintained by the University of Pacific School of Dentistry, San Francisco, California.
Support for the translation and dissemination of the Health Histories comes from MetLife Dental Care.

FIGURE 5-18 **The health history form for fictitious patient Mrs. Doi.**

Medication List

Patient DONNA DOI Date 1/30/XX

PRESCRIBED

PRENATAL VITAMINS

OVER-THE-COUNTER

SALINE NASAL SPRAY FOR DRY NOSE

VITAMINS, HERBS, DIET SUPPLEMENTS

METAMUCIL 1 TSP. PER DAY

FIGURE 5-19 **Medication list for fictitious patient Mrs. Doi.**

Health History Interview: PART 1

Patient Name: Doi, Donna D.

Directions: Record the number and details of any YES answer noted on the Health History.

Number	Significant Medical Findings	Dental Management Considerations

Medications	Dental Management Considerations

Date _____ Student Clinician Signature _____ Instructor Signature _____

FIGURE 5-20A **Mrs. Doi: health history synopsis part 1.**

Health History Interview: PART 2

Patient Name: Doi, Donna D.

Additional Information or Consultations

Directions: List any additional information that should be obtained before dental treatment begins.

Questions for Patient Interview

Directions: Formulate a list of questions for the patient interview.

FIGURE 5-20B **Mrs. Doi: health history synopsis part 2.**

Medical Consultation Request

To Dr: _____

_____

_____

RE: _____

_____

_____

Date of Birth: _____

Date _____

Please complete the form below and return to:

Dr: _____

_____

_____

Phone: _____

Fax #: _____

Dear Dr: _____

The above named patient has presented with the following medical problem(s): _____

_____

_____ Adrenal insufficiency or steroid therapy
_____ Anemia
_____ Anticoagulant therapy
_____ Bleeding disorder
_____ Cardiovascular disease
_____ Chemotherapy
_____ Diabetes
_____ Drug allergies
_____ Endocarditis
_____ Heart murmur
_____ Hepatitis
_____ HIV
_____ Hypertension
_____ Liver disease
_____ Leukemia
_____ Mitral valve prolapse
_____ Pacemaker
_____ Prescription diet drugs
_____ Prosthetic heart valve
_____ Prosthetic joint
_____ Pulmonary disease
_____ Radiation therapy to head/neck
_____ Renal dialysis with shunts
_____ Renal disease
_____ Rheumatic heart disease
_____ Systemic lupus erythematosus
_____ Systemic-pulmonary artery shunt
_____ Other: _____

Treatment to be performed on this patient includes:

_____ Oral surgical procedures
_____ Extractions
_____ Endodontic treatment (root canal)
_____ Deep scaling (with some removal of epithelial tissue)
_____ Dental radiographs (x-rays)
_____ Use of magnetostrictive ultrasonic devices
_____ Local anesthesia obtained with 2% Lidocaine, 1:100,000 epinephrine
_____ Local anesthesia epinephrine concentration may be increased to 1:50,0000 for hemostasis, but will NOT exceed 0.2mg total

Most patients experience the following with the above planned procedures:

_____ Minimal bleeding with transient bacteria
_____ Prolonged bleeding
_____ Stress and anxiety: ___ Low ___ Moderate ___ High
_____ Other: _____
_____ Appointment length: _____
_____ Number and frequency of appointments: _____
_____
_____

_____
Dentist's Signature

_____
Date

FIGURE 5-21 **Page 1 of medical consultation request for Mrs. Doi (if needed).**

MetLife University of the Pacific

HEALTH HISTORY - English

Patient Name: Eads, Esther E. Patient Identification Number: E-073218

Birth Date: 79 years

I. CIRCLE APPROPRIATE ANSWER (leave BLANK if you do not understand question):

1. Yes (No) Is your general health good?
2. (Yes) No Has there been a change in your health within the last year?
3. (Yes) No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? heart valve replaced and bypass surgery
4. (Yes) No Are you being treated by a physician now? For what? Heart problems
   Date of last medical exam? 6 weeks ago Date of last dental exam? 2 years ago
5. Yes (No) Have you had problems with prior dental treatment?
6. Yes (No) Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	(No)	Chest pain (angina)?	18.	Yes	(No)	Dizziness?
8.	(Yes)	No	Swollen ankles?	19.	Yes	(No)	Ringing in ears?
9.	(Yes)	No	Shortness of breath?	20.	Yes	(No)	Headaches?
10.	Yes	(No)	Recent weight loss, fever, night sweats?	21.	Yes	(No)	Fainting spells?
11.	Yes	(No)	Persistent cough, coughing up blood?	22.	Yes	(No)	Blurred vision?
12.	Yes	(No)	Bleeding problems, bruising easily?	23.	Yes	(No)	Seizures?
13.	(Yes)	No	Sinus problems?	24.	Yes	(No)	Excessive thirst?
14.	Yes	(No)	Difficulty swallowing?	25.	Yes	(No)	Frequent urination?
15.	Yes	(No)	Diarrhea, constipation, blood in stools?	26.	Yes	(No)	Dry mouth?
16.	Yes	(No)	Frequent vomiting, nausea?	27.	Yes	(No)	Jaundice?
17.	Yes	(No)	Difficulty urinating, blood in urine?	28.	Yes	(No)	Joint pain?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	(Yes)	No	Heart disease?	40.	Yes	(No)	AIDS?
30.	(Yes)	No	Heart attack, heart defects? 6 months ago	41.	Yes	(No)	Tumors, cancer?
31.	Yes	(No)	Heart murmurs?	42.	Yes	(No)	Arthritis, rheumatism?
32.	Yes	(No)	Rheumatic fever?	43.	Yes	(No)	Eye diseases?
33.	Yes	(No)	Stroke, hardening of arteries?	44.	Yes	(No)	Skin diseases?
34.	(Yes)	No	High blood pressure?	45.	Yes	(No)	Anemia?
35.	Yes	(No)	Asthma, TB, emphysema, other lung disease?	46.	Yes	(No)	VD (syphilis or gonorrhea)?
36.	Yes	(No)	Hepatitis, other liver disease?	47.	Yes	(No)	Herpes?
37.	Yes	(No)	Stomach problems, ulcers?	48.	Yes	(No)	Kidney, bladder disease?
38.	(Yes)	No	Allergies to: drugs, foods, medications, latex? Aspirin, Penicillin	49.	Yes	(No)	Thyroid, adrenal disease?
39.	Yes	(No)	Family history of diabetes, heart problems, tumors?	50.	Yes	(No)	Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51.	Yes	(No)	Psychiatric care?	56.	(Yes)	No	Hospitalization?
52.	Yes	(No)	Radiation treatments?	57.	(Yes)	No	Blood transfusions?
53.	Yes	(No)	Chemotherapy?	58.	(Yes)	No	Surgeries?
54.	(Yes)	No	Prosthetic heart valve?	59.	Yes	(No)	Pacemaker?
55.	Yes	(No)	Artificial joint?	60.	Yes	(No)	Contact lenses?

V. ARE YOU TAKING:

61.	Yes	(No)	Recreational drugs?	63.	Yes	(No)	Tobacco in any form?
62.	(Yes)	No	Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?	64.	Yes	(No)	Alcohol?

Please list: See Medication List

VI. WOMEN ONLY:

65.	Yes	(No)	Are you or could you be pregnant or nursing?	63.	Yes	(No)	Taking birth control pills?

VII. ALL PATIENTS:

64. (Yes) No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: osteoporosis; frequent infections of my legs

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature: Esther E. Eads Date: 1-15-20XX

RECALL REVIEW:

1. Patient's signature: _____ Date: _____
2. Patient's signature: _____ Date: _____
3. Patient's signature: _____ Date: _____

The Health History is created and maintained by the University of Pacific School of Dentistry, San Francisco, California.
Support for the translation and dissemination of the Health Histories comes from MetLife Dental Care.

FIGURE 5-22 The health history form for fictitious patient Ms. Eads.

Medication List

Patient ESTHER EADS Date 1/24/XX

PRESCRIBED

WARFARIN 5MG ONCE A DAY
CALAN SR (VERAPAMIL) 240MG EACH MORNING
ENALAPRIL 5MG TWICE A DAY
SIMVASTATIN 5MG ONCE A DAY IN PM

OVER-THE-COUNTER

VITAMINS, HERBS, DIET SUPPLEMENTS

MELATONIN ONE TABLET EACH EVENING

FIGURE 5-23 **Medication list for fictitious patient Ms. Eads.**

Health History Interview: PART 1

Patient Name: Eads, Esther E.

Directions: Record the number and details of any YES answer noted on the Health History.

Number	Significant Medical Findings	Dental Management Considerations

Medications	Dental Management Considerations

Date _____ Student Clinician Signature _____ Instructor Signature _____

FIGURE 5-24A Ms. Eads: health history synopsis part 1.

Health History Interview: PART 2

Patient Name: Eads, Esther E.

Additional Information or Consultations
Directions: List any additional information that should be obtained before dental treatment begins.

Questions for Patient Interview
Directions: Formulate a list of questions for the patient interview.

FIGURE 5-24B **Ms. Eads: health history synopsis part 2.**

Medical Consultation Request

To Dr: _____ Date _____

_____ **Please complete the form below and return to:**

_____ Dr: _____

RE: _____ _____

_____ _____

_____ Phone: _____

Date of Birth: _____ Fax #: _____

Dear Dr: _____

The above named patient has presented with the following medical problem(s): _____

_____

_____ Adrenal insufficiency or steroid therapy
_____ Anemia
_____ Anticoagulant therapy
_____ Bleeding disorder
_____ Cardiovascular disease
_____ Chemotherapy
_____ Diabetes
_____ Drug allergies
_____ Endocarditis
_____ Heart murmur
_____ Hepatitis
_____ HIV
_____ Hypertension
_____ Liver disease
_____ Leukemia
_____ Mitral valve prolapse
_____ Pacemaker
_____ Prescription diet drugs
_____ Prosthetic heart valve
_____ Prosthetic joint
_____ Pulmonary disease
_____ Radiation therapy to head/neck
_____ Renal dialysis with shunts
_____ Renal disease
_____ Rheumatic heart disease
_____ Systemic lupus erythematosus
_____ Systemic-pulmonary artery shunt
_____ Other: _____

Treatment to be performed on this patient includes:

_____ Oral surgical procedures
_____ Extractions
_____ Endodontic treatment (root canal)
_____ Deep scaling (with some removal of epithelial tissue)
_____ Dental radiographs (x-rays)
_____ Use of magnetostrictive ultrasonic devices
_____ Local anesthesia obtained with 2% Lidocaine, 1:100,000 epinephrine
_____ Local anesthesia epinephrine concentration may be increased to 1:50,0000 for hemostasis, but will NOT exceed 0.2mg total

Most patients experience the following with the above planned procedures:

_____ Minimal bleeding with transient bacteria
_____ Prolonged bleeding
_____ Stress and anxiety: ___ Low ___ Moderate ___ High
_____ Other: _____
_____ Appointment length: _____
_____ Number and frequency of appointments: _____
_____
_____

_____ _____
Dentist's Signature Date

FIGURE 5-25 **Page 1 of medical consultation request for Ms. Eads (if needed).**

SECTION 8 • Skill Check

Technique Skill Checklist: Medical History Questionnaire

Student: _____ Evaluator: _____

Date: _____

DIRECTIONS FOR STUDENT: Use **Column S**; evaluate your skill level as **S** (satisfactory) or **U** (unsatisfactory).

DIRECTIONS FOR EVALUATOR: Use **Column E**. Indicate **S** (satisfactory) or **U** (unsatisfactory). In the optional grade percentage calculation, each **S** equals 1 point, each **U** equals 0 point.

CRITERIA:	S	E
Reads through every line and "Yes/No" answer on the completed health history form. Identifies any unanswered questions on the health history form and follows up to obtain complete information.		
Makes notes about any information that is not clear or difficult to read. Confirms that the patient has signed and dated the form.		
Circles YES responses in red. Reads through all hand written responses and circles concerns in red.		
Researches medical conditions and diseases including definition, symptoms, and manifestations. Lists potential impact on oral health and any treatment concerns or needed modifications for dental treatment.		
Researches all prescription and OTC medications. Lists potential impact on oral health and any concerns or needed modifications for dental treatment.		
Formulates a list of follow-up questions for the patient interview.		
Formulates a preliminary opinion of the medical risk to the patient of dental treatment and whether a medical consult will be needed. (After completing the patient interview, discusses medical risk and need for medical consultation with a clinical instructor.)		
OPTIONAL GRADE PERCENTAGE CALCULATION		
Using the **E** column, assign a point value of 1 for each **S** and 0 for each **U**. Total the sum of the "**S**"s and divide by the total points possible to calculate a percentage grade.		

Communication Skill Checklist: Role-Play for Medical History

Student: _____ Evaluator: _____

Date: _____

ROLES:

- **Student 1** = Plays the role of a fictitious patient.
- **Student 2** = Plays the role of the clinician.
- **Student 3 or instructor** = Plays the role of the clinic instructor near the end of the role-play.

DIRECTIONS FOR STUDENT: Use **Column S**; evaluate your skill level as **S** (satisfactory) or **U** (unsatisfactory).

DIRECTIONS FOR EVALUATOR: Use **Column E**. Indicate **S** (satisfactory) or **U** (unsatisfactory). In the optional grade percentage calculation, each **S** equals 1 point, each **U** equals 0 point.

CRITERIA:	S	E
Explains the purpose of the medical history assessment to the patient.		
After researching medical conditions and medications, asks appropriate follow-up questions to gain complete information from the patient.		
Encourages patient questions before and during the medical history assessment.		
Answers the patient's questions fully and accurately.		
Communicates with the patient at an appropriate level and avoids dental/medical terminology or jargon.		
Accurately communicates the findings to the clinical instructor. Discusses the implications of the medical history findings for dental treatment. Uses correct medical and dental terminology.		
OPTIONAL GRADE PERCENTAGE CALCULATION		
Using the **E** column, assign a point value of 1 for each **S** and 0 for each **U**. Total the sum of the "**S**"s and divide by the total points possible to calculate a percentage grade.		

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