College of Dental Hygienists of British Columbia | College of Registered Dental Hygienists of Alberta | College of Dental Hygienists of Ontario / L'Ordre des hygiénistes dentaires de l'Ontario — Protecting your health and your smile / Nous protégeons votre santé et votre sourire

Canadian Performance Examination in Dental Hygiene
Health History Form

❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms. ❑ Dr. Last: First: Middle:			Date of Birth: _____ /_____/ _____ Year Month Day
Address (Home):		Phone:	Occupation:
City:		Postal Code:	Business Phone:
Height:	Weight:	Blood Pressure:	Pulse: Resp: Temp:

In case of emergency, we should notify:	Name:	Relationship:	Phone:
Family Doctor:	Phone:	Medical Specialist:	Phone:
Other Health Provider: (e.g., Occupational Therapist, Dietitian, Naturopath, Chiropractor)	Area of Specialty:	Address/Phone:	

Your safety and optimal oral health are our priorities. The following information enables us to provide you with the best oral health care services safely and effectively. **Please complete the entire form.** During your visit, you will be asked questions regarding your questionnaire responses. All information is confidential and treated in accordance with applicable provincial and federal privacy legislation.

A. DENTAL INFORMATION

1.	Do your gums bleed when you brush?	Y	N	9. Are you nervous during dental treatment?	Y	N
2.	Have you ever had orthodontic or orthotropic treatment (e.g., braces)?	Y	N	10. What is the reason for your dental visit?		
3.	Have you had any periodontal (gum) treatment?	Y	N	11. Date of last dental examination:		
4.	Are your teeth sensitive to hot, cold, sweets, or pressure?	Y	N	12. Date of last dental x-rays:		
5.	Have you ever had an injury to your head, face, or jaws?	Y	N	Please explain any YES answers:		
6.	Do you suffer from frequent headaches?	Y	N			
7.	Do you have earaches or neck pains?	Y	N			
8.	Do you have removable dental appliances? Implants?	Y	N			

B. GENERAL INFORMATION

1.	When was your last medical checkup? Date:				**Do you have or have you ever had:**		
2.	Are you being treated for any medical condition or have you been treated within the past year?	Y	N		12. Ear or hearing problems?	Y	N
3.	Has there been any change in your general health in the past year?	Y	N		13. Eye problems (e.g., require corrective lenses, glaucoma)?	Y	N
4.	Have you ever been hospitalized for any illnesses or operations?	Y	N		14. Sleep disorders?	Y	N
5.	Do you have a prosthetic or artificial joint (e.g., hip, knee)?	Y	N	**WOMEN**	15. Are you or could you be pregnant? If yes, expected delivery date:	Y	N
6.	Have you ever been advised to take antibiotics before dental treatment?	Y	N		16. Are you breastfeeding?	Y	N
7.	Have you ever had a peculiar or adverse reaction, including allergies, to any medications or injections?	Y	N		17. Are you taking hormone replacement therapy?	Y	N
8.	Do you have any allergies to any foods or materials (e.g., latex or metals)?	Y	N	Please explain any YES answers:			
9.	Do you have any other allergies (e.g., hay fever, animals)?	Y	N				
10.	Cancer?	Y	N				
11.	Dry mouth?	Y	N				

18. Are you taking medications of any kind? Include prescribed drugs, over-the-counter medications (e.g., cold and flu remedy), and natural health products (e.g., vitamins, herbal, and diet supplements). If yes, please list.

Drug Name	**Amount, Dose, Frequency** (e.g., One 80 mg tablet 3 times per day)	**Reason**	**Date Prescribed and Prescriber**

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C. CARDIO/RESPIRATORY

Do you have or have you ever had:		
1. Cardiovascular diseases? If yes, specify below:	Y	N
❑ Angina ❑ Heart attack ❑ Arteriosclerosis ❑ Heart murmur ❑ Artificial heart valves ❑ High or low blood pressure ❑ Congenital heart defects ❑ High or low cholesterol ❑ Congestive heart failure ❑ Mitral valve prolapse ❑ Coronary artery disease ❑ Pacemaker/defibrillator ❑ Damaged heart valves ❑ Rheumatic heart disease/fever		
2. Chest pains upon exertion?	Y	N
3. Shortness of breath?	Y	N
4. Asthma?	Y	N
5. Chronic bronchitis or emphysema?	Y	N
6. Sinus trouble or nasal congestion?	Y	N
7. Tuberculosis?	Y	N
8. A persistent cough for more than 3 weeks?	Y	N
9. Cough that produces blood?	Y	N
Please explain any YES answers		

D. ENDOCRINE/DIGESTIVE

Do you have or have you ever had:		
1. Malnutrition?	Y	N
2. Eating disorder?	Y	N
3. Dietary restrictions (self-imposed or doctor prescribed)?	Y	N
4. Night sweats?	Y	N
5. Slow healing or recurrent infections?	Y	N
6. Thyroid or parathyroid disease?	Y	N
7. Diabetes? If yes, indicate type:	Y	N
Please explain any YES answers:		

E. GASTEROINTESTINAL/GENITOURINARY

Do you have or have you ever had:		
1. Hepatitis, jaundice, or liver disease?	Y	N
2. Difficulty swallowing?	Y	N
3. G.E. reflux/persistent heartburn?	Y	N
4. A stomach ulcer?	Y	N
5. Gall bladder problems?	Y	N
6. Kidney or bladder trouble?	Y	N
7. Excessive urination?	Y	N
Please explain any YES answers:		

F. HEMATOLOGIC

Do you have or have you ever had:		
1. Prolonged or abnormal bleeding with a simple cut or following surgery, extraction, or an accident?	Y	N
2. A blood transfusion? If yes, date:	Y	N
3. A tendency to bruise easily?	Y	N
4. Any blood disorder (e.g., anemia or hemophilia)?	Y	N
Please explain any YES answers:		

G. IMMUNE SYSTEM/INFECTIOUS DISEASES

Do you have or have you ever had:		
1. Systemic lupus erythematosus?	Y	N
2. Painful swollen joints or rheumatoid arthritis?	Y	N
3. HIV/AIDS?	Y	N
4. Other diseases or conditions that affect your immune system (e.g., sarcoidosis, Epstein-Barr, radiotherapy, chemotherapy, steroid therapy)?	Y	N
5. Sexually transmitted diseases (e.g., herpes)?	Y	N
6. Have you ever had an antibiotic resistant infection (e.g., MRSA)?	Y	N
Please explain any YES answers:		

H. NEUROLOGICAL/MUSCULOSKELETAL

Do you have or have you ever had:		
1. A stroke?	Y	N
2. Convulsions or seizures (e.g., epilepsy)?	Y	N
3. Mental health disorders?	Y	N
4. Arthritis?	Y	N
5. Osteoporosis or osteopenia?	Y	N
6. Chronic pain?	Y	N
Please explain any YES answers:		

I. OTHER

1. Do you smoke, chew, or snort tobacco products?	Y	N
If yes: Frequency (daily, weekly)?		
Number of years use?		
Have you ever tried to quit?	Y	N
Are you interested in quitting?	Y	N
2. Do you have a drug or alcohol dependency?	Y	N
3. Other diseases or medical problems that run in your family?	Y	N
4. Other conditions or medical problems not listed?	Y	N
5. Other special needs that will affect your dental care?	Y	N
Please explain any YES answers:		

To the best of my knowledge, the above information is correct.

Client/Parent/Guardian Signature: _____ Date: _____

Reviewed by: _____(DDS, RDH) Date: _____

Notes **ASA CLASSIFICATION: I II III IV V E**

Comments on client interview concerning health history.

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_____

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_____

Significant findings from questionnaire or verbal interview.

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Considerations for the care plan.

_____

_____

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CPEDH Evaluation Date: _____

Client Name: _____

Candidate ID#: _____

Rater ID# and Signature:

_____