CDHO
COLLEGE OF DENTAL
HYGIENISTS OF ONTARIO

Guideline: A Check-Up for Health and Dental History Taking
(Medical/Dental History Guide)

The College of Dental Hygienists of Ontario (CDHO) recognizes that there are many excellent health and dental history forms currently being used in various dental hygiene practice settings. History forms provide the basis for the data collection that will influence the delivery of dental hygiene care. During the assessment phase of the dental hygiene process of care, the dental hygienist determines the client's health status, risks, disease severity, contraindications to care, the necessity for medical consultation and considerations for medical emergency prevention. Dental hygienists recognize that dental hygiene care implementation is significantly influenced by the client's health status and that the client's overall health may be influenced by conditions present in the oral cavity. Therefore, health and dental histories must be reviewed and updated at the commencement of each dental hygiene care appointment. The dental hygienist has an obligation to maintain confidentiality to only collect and use information for the stated purpose, in accordance with the legislation.

In order to obtain a complete history, the dental hygienist systematically collects, analyzes and records information based on direct observation of the client, completion of a written health and dental history questionnaire and accompanying oral interview. The oral interview, which is a comprehensive discussion between the client and the practitioner, builds on information obtained from the written history questionnaire and is an integral step in obtaining complete and accurate information from the client.

The attached information is intended to be a template (guide) only. Dental hygienists may choose to refer to this template when they are reviewing their current history forms or when they are developing a form for specific use. The template is not intended to be all-inclusive, nor is it intended to be a standard by which histories are compared. In addition, some questions may not be necessary to ask in all settings or circumstances. The format has deliberately been left flexible so that registrants may design a form suited to their particular practice settings.

If developing a form(s) for clients to fill out directly, there should be a statement at the beginning of the form(s) explaining why the information is being collected.

PERSONAL HISTORY

- Name, address, telephone numbers, gender, marital status, date
- Date of birth
- Height and weight
- Occupation
- Parent/guardian if client is a minor
- Dentist's name, address and phone number
- Physician's name, address and phone number
- Emergency contact and phone number
- Referral source

HEALTH HISTORY

General Medical History

- Reason for seeking dental hygiene care at this time?
- Are you in good general health?
- Any change in your general health in the past year?
- Are you under the care of a physician?
- Date of last physical examination?
- Have you been hospitalized or had a serious illness or operation?
- Have you gained or lost more than 10 pounds in the last year?
- How many medical and dental x-rays have you had in the past five years?
- Have you ever had any complications following dental treatment?
- Would you say your diet is adequate and balanced?
- Do you wear contact lenses?
- Do you smoke?
  - Yes
  - No
  - If yes, how many per day? _____ Years smoked? _____
- Are you interested in taking part in a smoking cessation program?
- Do you consume alcohol? _____
  - If yes, how many drinks per day _____ /week _____

MEDICATIONS / ALLERGIES

- Are you taking any medications – prescribed, over-the-counter or herbal remedies?
  List them _____ (note dose and frequency)
- Are you taking / do you take recreational drugs?
- Have you ever taken appetite suppressants?
  - Yes
  - No
- What type/when _____
- Are you allergic to any medications, foods, drugs, metals, latex? _____
- Have you ever had hives?
  - Yes
  - No
- Have you experienced an unusual reaction or allergy to penicillin, aspirin, sulpha drugs, codeine, cortisone (steroids), local anaesthetics, topical anaesthetics, barbiturates (sleeping pills), tranquillizers or other medications, food, dental latex?
  - Yes
  - No
- Do you have a drug/alcohol dependency?
  - Yes
  - No _____

CARDIOVASCULAR SYSTEM

- Heart disease, heart failure, heart attack, chest pain
- Angina pectoris, pacemaker, artificial heart valves
- History of infective endocarditis
- Congenital heart disease, swollen ankles
- Shortness of breath, heart surgery/bypass
- High blood pressure, low blood pressure
- Do you use extra pillows for sleeping?

BLOOD CONDITIONS

- Cerebrovascular accident (stroke), anaemia
- Prolonged bleeding or blood disorder, leukaemia
- Haemophilia, bruise easily, heal slowly
- Immunodeficiency problems, HIV, AIDS, lupus, sickle cell anaemia
- Have you ever had a blood transfusion?

RESPIRATORY SYSTEM

- Lung disease, persistent cough or cold
- Tuberculosis, emphysema
- Bronchitis, pneumonia, asthma/hay fever
- Shortness of breath, sinus problem

GASTROINTESTINAL / DIGESTIVE SYSTEM

- Stomach ulcers/acid reflux, hepatitis (A, B or C, other)
- Jaundice, liver disease
- Have you ever vomited blood?
- Diarrhea

GENITOURINARY SYSTEM

- Kidney disease/disorder, syphilis, gonorrhea
- Sexually transmitted diseases/infections, herpes

BONES / JOINTS

- Arthritis, swollen joints, inflammatory rheumatism
- Artificial joints (hip, knee or joint), osteoporosis

NEUROLOGICAL / PSYCHOLOGICAL CONDITIONS

- Fainting spells, seizures, frequent headaches
- Frequent exhaustion, epilepsy
- Paralysis, Alzheimer's disease
- Multiple sclerosis/demyelinating disease, Parkinson's disease, Clinical depression/anxiety/psychiatric treatment

ENDOCRINE SYSTEM

- Diabetes controlled/uncontrolled, if yes. Type I (insulin dependent) Type II
- Frequent urination, frequent thirst
- Thyroid disease: hypothyroidism, hyperthyroidism, hypoglycaemia

SENSORY / PHYSICAL DISABILITIES

- Eye disease, glaucoma, blindness
- Hearing disorders, changes in taste
- Cerebral palsy, immunosuppressions
- Cancer treatment
- Have you ever had a cortisone treatment?
- Have you ever had any treatment for a tumour or growth?
- Have you ever had radiation or chemotherapy for cancer or leukaemia?
- Have you ever had an organ transplant?
- Have you had any other condition or disease not previously mentioned?

WOMEN / PREGNANCY / MENOPAUSE

- Are you pregnant?
- Are you nursing?
- Are you taking birth control medications?
- Are you taking hormone replacement?

DENTAL HISTORY

- Date of last dental/dental hygiene visit _____
- What dental conditions concern you at the present time? _____
- What care did you receive at the last dental visit? _____
- How often do you receive dental treatment or dental hygiene care? _____
- Do you require complete mouth care or emergency treatment? _____
- Are you under the care of a dental specialist?
  (i.e., orthodontist, endodontist, prosthodontist, periodontist) _____
- Have you ever had a thorough examination of your mouth including a complete set of radiographs (16-20 films) of your jaws and teeth?
  - Yes
  - No
  - When? _____
- Have you had radiographs (dental x-rays) in the past two years?
  - Yes _____ Type: _____
  - No _____
- Head and neck radiation therapy?
- Have you had any dental problems within the last year with your teeth, gums, jaws, chewing?
  - Yes
  - No

- In order that we may be sensitive to your needs, please tell us of any unpleasant experiences you may have had related to oral care. _____

Do you have or have you ever experienced any of the following?

- Sensitive teeth (hot or cold), cold sores
- Bleeding gums (on brushing), sore gums
- Loose teeth, dry mouth
- Recession, bad breath
- Swelling, sinus problems
- Sore jaw, jaw clicks or pops on opening or closing
- Mouth sores, difficulty chewing
- Difficulty swallowing, burning sensation
- Calculus (tartar) build-up, toothache
- Fractured or broken filling, abscess
- Yellowing or discolouration of teeth
- Grinding of teeth – any accident, injury or surgery to your face, jaw or teeth?

Have you experienced any of the following?

- Scaling/root planning (cleaning), tooth extractions
- Dental implants, root canals
- Gum/jaw surgery, orthodontics/braces
- Severe pain in head, neck or jaw
- Prolonged bleeding after dental treatment
- Other _____

Current oral condition

- Do you brush your teeth? How often? _____
- Do you floss your teeth? How often? _____
- What oral aids do you routinely use at home? _____
- Do you want to keep your natural teeth?
  - Yes
  - No
- Do you have complete dentures – partial dentures – fixed bridges – implants
- Do you clean your dental appliances? _____
- Are you a mouth breather?
  - Yes
  - No
- Do you favour one side of your mouth?
  - Yes
  - No

All "yes" answers require a detailed interview and support documentation.

A section for consent should be inserted that is in compliance with both the *Personal Information Protection and Electronic Documents Act* (PIPEDA) and *Personal Health Information Protection Act* (PHIPA). Then have the client date and sign the form.

HEALTH AND DENTAL HISTORY UPDATE

The following sample questions may be used at the time of the health/dental history interview.

1. Is there any change in your health and dental history from the last visit?
2. Are you taking medication? Are you taking any new medications?
3. Are you allergic to any drugs, foods, metals or latex?
4. Are you seeing a physician for any condition, including pregnancy?
5. Have you ever had heart disease/problems, infective endocarditis, hip, knee or joint replacement?
6. Since the last visit have you been hospitalized for any reason?
7. What other recent changes in your health/dental history have occurred since your last visit?

A section for consent should be inserted that is in compliance with both PIPEDA and PHIPA. Then, have the client date and sign the form.

References:

Darby, M and Walsh, M: *Dental Hygiene Theory and Practice*, 2nd Edition, W.B. Saunders Company, Philadelphia, 2003
Daniel, S. J. and Harfst, S. A.: *Mosby's Dental Hygiene Concepts, Cases and Competencies,* Mosby, St. Louis, 2002
Wilkins, E.: *Clinical Practice of the Dental Hygienist,* 9th Edition, Lippincott, Williams and Wilkins, Philadelphia, 2004

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