Prairie State College

Dental Hygiene Program
Student Health History and Physical Evaluation Form-Part 1

This form includes two parts. Please complete Part 1 and take it with you to your appointment with your health care provider. Your provider will complete Part 2.

PART 1: HEALTH HISTORY – to be completed by the student and presented to the health care provider.

List any prescription or non-prescription medications you are taking: _____

_____

_____

List any allergies: _____

Are you pregnant? _____ Due date: _____

Have you had chicken pox? ☐ Yes ☐No When: _____

Please check if you or a family member has a history of any of the following conditions:

Condition	Self	Family	Explanation
Arthritis			
Back Problems			
Cancer			
Diabetes			
Hearing Impairment			
Heart Problems			
Hepatitis			
High Blood Pressure			
Kidney Problems			
Lung Problems			
Orthopedic Problems			
Seizures			
Speech Problems			
Surgeries			
Tuberculosis			

Emergency Contact Information:

Name: _____ Relationship to Student: _____

Phone #: _____ Address: _____

The information provided is true and correct to the best of my knowledge and I am aware that this information will be released to clinical affiliations upon request.

Student Signature: _____ Date: _____

I verify that I have reviewed this information with student.

_____ _____

Signature of Physician/ Nurse Practitioner Print Name of Physician/ Nurse Practitioner

Dental Hygiene Program

PHYSICAL EXAMINATION FORM-PART 2

STUDENT'S NAME: _____ DATE: _____
last first middle

ADDRESS: _____

CITY AND STATE: _____ ZIP CODE: _____

To the Applicant: *This form must be completed by an MD, DO, or NP.*

Part I

Vital Signs:

Temperature _____ Pulse _____ Respiration _____ Blood Pressure _____
Height _____ Weight _____

Record Findings: Indicate any Abnormalities

- ❒ Skin and Nails
- ❒ Head
- ❒ Ears/Hearing
- ❒ Nose and Sinuses
- ❒ Mouth and Pharynx
- ❒ Neck
- ❒ Nodes
- ❒ Thorax
- ❒ Endocrine System
- ❒ Gastrointestinal System
- ❒ Pulmonary/Respiratory System
- ❒ Genitourinary System
- ❒ Hematologic System
- ❒ Immune System
- ❒ Cardiovascular System
- ❒ Musculosketetal System
- ❒ Neurological System
- ❒ Behavioral, Psychiatric

1. Describe any abnormality and/or any condition **that requires pre-medication prior to dental treatment according to AHA or AAOS guidelines.**

_____

_____

2. What pre-medication and what regimen would be prescribed?? _____

_____

3. Prescription medications (dosage, regime, reason): _____

_____

Part II

To be completed by a specialist.

Eye Exam: Normal ❒ Yes ❒ No Abnormal ❒ Yes ❒ No

1. If abnormal, please list the abnormality and recommendations for treatment, if any.

_____

2. Does this person require vision correction? _____
3. Are glasses or contact lenses recommended for daily use? _____

PHYSICAL EXAMINATION (continued)

PART III.

On the basis of your History and Physical Examination, is it your professional opinion that this person is capable of participating in a dental hygiene program*? ☐ Yes ☐ No

***Dental hygiene involves essential functions such as:**

Mobility	Physical abilities (including standing, walking, bending, range of motion of extremities) to move from room to room and maneuver in small spaces.	Able to administer cardiopulmonary resuscitation; move around in patient treatment area.
Motor	Gross and fine motor function sufficient to provide safe and effective dental hygiene care.	Able to use dental instruments, manipulate various dental materials.
Hearing	Auditory ability sufficient to monitor and assess health needs.	Able to listen to breath and heart sounds. Able to hear equipment monitors, such as x-ray equipment and autoclave timers.
Visual	Visual ability sufficient to provide safe and effective dental hygiene care.	Able to observe patients and use instruments in the oral cavity. Adequate close vision to see small lesions and deposits on teeth.
Cognitive	Critical thinking ability Verbal and written communication skills	Cause and effect relationships in clinical diagnosis and effective interaction with patients and other health care professionals

What restrictions, if any, would you advise?_____

_____

Any allergies? _____

_____

Drug sensitivities? _____

_____

Is applicant free of communicable disease? ☐ Yes ☐ No

Comments: _____

_____

TESTS REQUIRED ON ALL STUDENTS.

To the health care provider; please provide student with copies of laboratory results and any immunization records. DO NOT HAVE RESULTS MAILED SEPARATELY.

1) **CBC**
2) **Serology (RPR)**
3) **Microscopic Urinalysis**
4) **TB Test**

Must be **ONE** of the following:

a) Two-step Tuberculin Skin Test (TST)
Initial TST placed and then must be read 48 - 72 hours later and if negative, then a second TST placed one - three weeks after the first TST was read. The second TST must be read 48-72 hours after it was placed.

b) QuantiFERON-TB Gold blood test (QFT-G)

TST: Initial date:_____ Date read: _____
Second date:_____ Date read: _____

OR

QFT-G : Date: _____ Result: _____

Positive Results

Any student with a positive TST or QFT-G must be seen and evaluated by their physician to rule out TB. They must have a chest x-ray (2 views) that is negative for TB. The student must provide:

1) A copy of the chest x-ray report.
2) Letter from the physician that they have been evaluated and ARE NOT CONTAGIOUS and that TB has been ruled out.
3) A completed TB questionnaire.

5) 10 Panel Drug Test using designated lab. (Lab Corp. or Quest are the labs that can be used.)

6) TITERS REQUIRED: (Immunization Required if NON-IMMUNE)

RUBELLA

Rubella titer: _____ ☐ Immune

Date of testing: _____ ☐ Non-immune

Immunization required if non-immune

Date of immunization: _____

RUBEOLA

Rubeola titer: _____ ☐ Immune

Date of testing: _____ ☐ Non-immune

Immunization required if non-immune

Date of 1st dose: _____ Date of 2nd dose: _____

MUMPS

Mumps titer:_____ ☐ Immune

Date of testing:_____ ☐ Non-immune

Immunization required if non-immune

Date of 1st dose: _____ Date of 2nd dose: _____

VARICELLA

Varicella titer:_____ ☐ Immune

Date of testing:_____ ☐ Non-immune

Immunization required if non-immune

Date of 1st dose: _____ Date of 2nd dose: _____

MMR and Varicella vaccines are contraindicated during pregnancy.

IMMUNIZATIONS REQUIRED:

HEPATITIS B

Immunization required if non-immune

Date of 1st dose: _____ Date of 2nd dose: _____ Date of 3rd dose: _____

If no proof of immunization, titer required:

Date of titer: _____ Immune: _____ Non-Immune: _____

TETANUS

Tdap booster required within the last 10 years

Date of booster:_____

(Influenza Vaccine required during flu season - by November 1)

Physician's Signature: _____ Date: _____

Please Print

Physician's Name: _____

Office Address: _____

Physician's Phone: _____

Tuberculosis Questionnaire

Please complete the form below if you have ever had a positive reaction to a Tuberculosis Skin Test.

Date of first positive TB skin test:		Measurement:	mm

Have you ever had TB? ☐ Yes ☐ No

Were you treated with medication? ☐ Yes ☐ No

Medication name: _____

Length of treatment: _____

Have you ever had BCG? ☐ Yes ☐ No

Symptoms Review: Do you have any of the following?

Chronic cough?	Yes	No
Persistent night sweats?	Yes	No
Chronic fatigue?	Yes	No
Involuntary weight loss?	Yes	No

Are you being treated for any serious medical conditions? ☐ Yes ☐ No

Please describe: _____

Are you under treatment of Prednisone, Cancer Chemotherapy, or X-Ray Therapy? ☐ Yes ☐ No

Please describe: _____

Student's Printed Name: _____

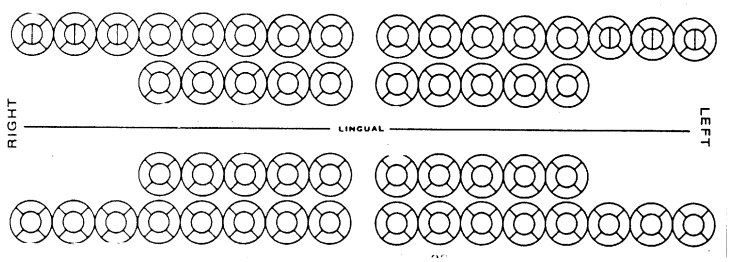
Student's Signature: _____

DENTAL EXAMINATION FORM

To the Applicant: Please complete and submit as directed prior to the beginning of classes.

STUDENT'S NAME: _____ D ATE: _____
LAST FIRST MIDDLE

ADDRESS: _____
CITY STATE ZIP CODE



ORAL HYGIENE:

Condition of teeth: _____
Condition of mucosa: _____
Was a fluoride treatment given: _____
Date of last dental visit: _____
Last panorex: _____
___ Last full series radiographs: _____
___ Last BW's: _____
Is orthodontia indicated: _____
Date ortho completed: _____

Dental Hygiene Diagnosis
☐ Healthy ☐ Moderate Periodontitis
☐ Gingivitis ☐ Advanced Periodontitis
☐ Early Periodontitis
Is premedication required prior to dental treatment? _____

Have missing teeth been replaced: _____
a. by orthodontia: _____
b. by fixed bridgework: _____
c. by removable partial: _____
d. by full denture: _____
e. by implants: _____

Type of occlusion: ☐ normal ☐ abnormal
Dental work completed: ☐ yes ☐ no
Date completed: _____
Has student whitened his/her teeth? ☐ yes ☐ no
Has student experienced any difficulty with local
anesthetics? ☐ yes ☐ no
nitrous oxide? ☐ yes ☐ no
Explain: _____
_____

Dentist's Signature: _____
Address: _____ City, State, Zip: _____
Office Phone Number: (___) _____

Key:
Missing teeth - Blue X To be extracted - Red X Restorations - Blue
Dental Caries - Red Impacted - IMP Pontics _____