

STATE OF ALASKA
DENTAL HISTORY RECORD

DEPARTMENT OF CORRECTIONS

PATIENT NAME _____

BIRTH DATE _____

INSTITUTION _____

OTIS _____

ANSWER THE FOLLOWING QUESTIONS / CIRCLE Yes OR No

MEDICAL HISTORY

- 1. Are you under any medical treatment now? Yes No
- 2. Have you been treated by a physician (doctor) or hospitalized in the past year? Yes No
- 3. Have you ever had any surgical operations or serious illness? If so, what? _____ Yes No
- 4. Have you ever had a serious head injury? Yes No
- 5. Are you now taking drugs or prescribed medications? If so, what? _____ Yes No
- 6. Are you allergic to ANY drugs or medicines such as penicillin, other antibiotics, aspirin, codeine, etc.? . Yes No

HAS A PHYSICIAN EVER INFORMED YOU THAT YOU HAD

- 7. Heart Ailment or Problem? Yes No
- 8. High Blood Pressure? Yes No
- 9. Respiratory Disease such as Tuberculosis (TB) or Asthma? Yes No
- 10. Diabetes (yourself or your family)? Yes No
- 11. Rheumatic Fever? Yes No
- 12. Rheumatism or Arthritis? Yes No
- 13. Blood Disease? Yes No
- 14. Liver Disease? Yes No
- 15. Yellow Jaundice (Hepatitis)? Yes No
- 16. Kidney Disease? Yes No
- 17. Stomach or Intestinal Disease? Yes No
- 18. Stomach Ulcer? Yes No
- 19. Venereal Disease? Yes No
- 20. Seizures or Epilepsy? Yes No
- 21. HIV or AIDS? Yes No
- 22. Cancer, Tumors, or Growths? Yes No
- 23. Are you allergic to any known materials resulting in hives, asthma, eczema, etc? Yes No
- 24. Are you in GOOD GENERAL HEALTH at this time? Yes No
- 25. Have you ever had any RADIATION TREATMENTS (such as for cancer)? Yes No
- 26. Do you have any artificial joints, pins, posts, screws, or metal plates in your body? Yes No
- 27. Have you ever tested positive to TB? Yes No
- 28. Do you bleed easily, or for long periods? Yes No
- 29. Do you faint easily? Yes No
- 30. Do you have any other diseases or conditions not listed here? Yes No

DENTAL HISTORY

- 31. What is your main immediate dental concern? _____
- 32. Do you have a toothache or are you in pain now? Yes No
- 33. Do you have any sores, growths, or injuries in your mouth? Yes No
- 34. Have you ever had local anesthetic such as Novocaine, Lidocaine, etc.? Yes No
- 35. Have you ever had any reactions or allergic symptoms to anesthetic? Yes No
- 36. Do your gums bleed easily? Yes No
- 37. Have you ever had instructions on the care of your gums and teeth? Yes No
- 38. Do you believe you floss and brush well? Yes No
- 39. When were your last dental X-RAYS taken? _____
- 40. When was your last dental appointment? _____ Where? _____

FOR WOMEN ONLY

- 41. Are you pregnant? Yes No
- 42. Are you taking hormones or contraceptives? Yes No

PATIENT'S SIGNATURE _____

DATE _____

Form Instructions - Dental History Record

Each inmate is to complete a Dental History Record when he or she is first seen in the dental clinic and each time the inmate has been freed and subsequently incarcerated. The dentist is to review the information with the inmate, initially and at each subsequent visit. After each review, the dentist is to initial and date the back of the Record in the spaces provided.

If the inmate enters problems in the Dental History Record that may require precautions before or after dental treatment is initiated, verify the inmate's condition with the medical department. Note any required precautions (for example, allergies) on the back of the Record in the comments section.

The dentist is responsible for making his own professional decisions concerning the treatment to be done and its impact on the inmate's current and future medical treatment and condition.

Note: The dentist is not to enter medical history information or his decision for action in any section of the Dental Initial Record or any Dental Continuation Record(s). This information goes in the space provided on the back of the Medical History Form.