MARQUETTE UNIVERSITY SCHOOL OF DENTISTRY
MEDICAL HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME: _____ TODAY'S DATE: ____/____/____
DATE OF BIRTH: ____/____/____

The following information about your health is very important. It allows us to provide you with the safest possible treatment. Incorrect information may be dangerous to your health. Please answer all questions completely and accurately. If you do not understand a question or are unsure of the answer or wish to discuss it with a dentist, please inform the student dentist or faculty member in the clinic. The information on this Health History Questionnaire will be viewed by appropriate Dental School personnel only and will be considered confidential information.

1. Are you in good health? Yes No Don't Know

2. When was your last physical examination? ____/____/____
   What was the result? _____

3. Are you presently being treated by a physician? Yes No

4. List medications you are taking (prescription and non-prescription, over-the-counter, vitamins, oral contraceptives, etc.)

_____
_____
_____
_____

5. Are you allergic to or have had bad reactions to medication or anything else? (Please list medication and type of reaction).

_____
_____
_____
_____

6. Are you allergic to latex? Yes No

Have you ever had or do you presently have any of the following: (circle Yes or No)

7. Arthritis	Yes	No
8. Diabetes	Yes	No
9. Thyroid problem	Yes	No
10. Asthma	Yes	No
11. Tuberculosis	Yes	No
12. Shortness of breath	Yes	No
13. A need for extra pillows when you sleep	Yes	No
14. Heart problems/surgeries	Yes	No
15. Congenital heart problems/transplants	Yes	No
16. History of Infective Endocarditis (infection inside the heart)	Yes	No
17. Heart valve problems	Yes	No
18. A prosthetic heart valve or heart valve replacement	Yes	No
19. Pacemaker	Yes	No
20. High blood pressure	Yes	No
21. Low blood pressure	Yes	No
22. Chest Pain	Yes	No
23. Swollen ankles	Yes	No

For Doctor's Use Only:			
Drug Name	**Pharmacological Category**	**Reason for Taking Medication**	**Dental Implications/Possible Oral Side Effects**
Example: Coumadin	*Anticoagulant*	*Hx. of DVT*	*Increased bleeding/spontaneous gingival bleeding*

24. Abnormal bleeding	Yes	No
25. Anemia	Yes	No
26. Fatigue easily	Yes	No
27. Jaundice	Yes	No
28. Hepatitis	Yes	No
Type of hepatitis (if known)		
29. Liver disease	Yes	No
30. Contact with HIV (AIDS virus)	Yes	No
31. Blood transfusions	Yes	No
32. Sexually transmitted disease	Yes	No
33. Kidney disease	Yes	No
34. Epilepsy	Yes	No
35. Fainting spells	Yes	No
36. Nervous disorder/psychiatric care	Yes	No
37. Non-malignant tumor	Yes	No
38. Malignant tumor/cancer	Yes	No
39. Radiation therapy to head or neck region	Yes	No
40. Artificial joint	Yes	No
When was your most recent prosthesis placed?		
41. Do you have a history of narcotic abuse?	Yes	No
42. Do you have a history of alcohol abuse?	Yes	No
43. Have you ever been told you require premedication prior to dental treatment?	Yes	No
44. Have you ever been treated for osteoporosis?	Yes	No
45. Are you being treated for any other bone disease or cancer?	Yes	No
46. Have you taken, or are you taking, any of the following medications:		
Aredia (pamidronate)	Yes	No
Zometa (zolendronic acid)	Yes	No
Actonel (risendronate)	Yes	No
Fosamax (alendronate)/Boniva (ibandronate)	Yes	No
47. Have you ever been turned down as a blood donor?	Yes	No
48. **FOR WOMEN ONLY**: Are you pregnant?	Yes	No

49. List any other conditions (including all surgical procedures)

A. _____

B. _____

C. _____

50. Have you been hospitalized in the past five years? Yes No

If yes, for what condition? _____

Date	Blood Pressure	Pulse Rate	Temperature	Respiratory Rate
	/			

To the best of my knowledge, I have answered every question completely and accurately. I will inform my student dentist of any changes in my health and/or medication. I also give permission to Marquette University School of Dentistry to perform the procedures considered necessary for my emergency treatment and/or initial dental care to include but not limited to a screening exam and radiographs.

Patient/legal guardian signature	Faculty signature/ID#	Student signature/ID#	Date
Patient/legal guardian signature	Faculty signature/ID#	Student signature/ID#	Date
Patient/legal guardian signature	Faculty signature/ID#	Student signature/ID#	Date

Other Permitted or Required Uses and Disclosures Not Requiring Your Authorization

Business associates: There are some services provided in our organization through contacts with business associates. Examples include radiology, laboratory tests, and computer support. When these services are contracted, we may disclose your health information to our business associate so they can perform the job we've asked them to do. Business associates will safeguard your information.

Notification: With your authorization, we may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: With your authorization, health professionals, using their best judgement, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Marketing and Fundraising: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also contact you to raise funds for MUSoD.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols or agreements to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Military, National Security, Correctional Institution: Should you be involved with the military, national security, intelligence activities or an inmate of a correctional institution, we may disclose to the proper authorities thereof your health information so those proper authorities may carry out their legal duties.

Legal: We must disclose health information for law enforcement purposes in applicable cases of abuse, neglect or violence, in response to a valid subpoena or as otherwise required by law.

NOTE: Except as described in this notice, we must obtain your specific written authorization for any other release of your health information. If you sign an authorization form, you may withdraw your authorization at any time in writing. This Notice is effective April 14, 2003.

MARQUETTE UNIVERSITY SCHOOL OF DENTISTRY

Notice of Health Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

MUSOD HIPAA Form # 1 (April 14, 2003)

Understanding Your Health Information

Each time you visit a dentist, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. Being aware of what is in your dental record will help you to make more informed decisions when authorizing disclosure to others.

Your dental record, serves as a:

- basis for planning your care and treatment.
- means of communication among the many health professionals who contribute to your care.
- legal document describing the care you received.
- tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.
- means by which you or an insurance company can verify that services billed were actually provided.
- source of data for facility planning and marketing services.
- source of information for public health officials charged with improving the health of the nation.

Your Health Information Rights

Although your dental record is the physical property of Marquette University School of Dentistry, the health information it contains belongs to you. You have the right to:

- inspect and obtain a copy of your health information; there are a few exceptions and copy charges may apply.
- request to amend your health information.
- revoke your authorization to use or disclose health information except to the extent that action has already been taken prior to revocation.
- request a restriction on certain otherwise permitted uses and disclosures of your information; however, we are not required to agree in all circumstances.
- request a written accounting of disclosures of your health information for the previous six years but not before April 14, 2003 for disclosures other than those made to you, for treatment, payment, or healthcare operations or other limited exceptions.
- request communications of your health information by alternative means or at alternative locations and to obtain a paper copy of this notice upon request.

If you wish to exercise any of these rights, please contact MUSoD's Privacy Officer at (414) 288-6105 for details.

Marquette University School of Dentistry

- will as required by law maintain the privacy of your health information.
- will provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you .
- will abide by the terms of the notice currently in effect.
- will notify you if we are unable to agree to a requested restriction.
- will accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will post the revised information on our web site at www.marquette.edu/hipaa and provide you with a copy.

For More Information or to report a Problem

If you have questions and/or would like to report a problem or complaint, you may contact the MUSoD Privacy Officer at (414)288-6105. If you feel the privacy of your health information has been compromised or your rights violated you may contact either the Privacy Officer, the University contact person for receiving HIPAA complaints at (414) 288-7305, or the Secretary of Health and Human Services. We will not retaliate against you for filing a complaint.

Examples of Disclosures for Treatment, Payment and Healthcare Operations

We will use your health information for treatment.

For example: Information obtained by a dentist, nurse, clinician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will record the actions they took and their observations. In that way, the health care team will know how you are responding to treatment.

We will use your health information for payment.

For example: If you have a charge you may receive an invoice at the time of the visit. The information on or accompanying the invoice may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for operations.

For example: Members of the MUSoD staff may use information in your dental record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

MARQUETTE UNIVERSITY SCHOOL OF DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

- I hereby acknowledge the receipt of Marquette University's School of Dentistry Notice of Health Information Privacy Practices:

Please print your Name

Signature

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Health Information Privacy Practices, but acknowledgement could not be obtained because of the following reason(s):

- ❑ Individual refused to sign.
- ❑ Communications barriers prohibited obtaining the acknowledgement.
- ❑ An emergency situation prevented us from obtaining acknowledgement.
- ❑ Other (please specify):

_____
_____
_____
_____
_____

<file in consent forms section>