UTHealth | School of Dentistry
The University of Texas Health Science Center at Houston

Special Patient Clinic
Medical Data Form

IMPORTANT:
This medical history form is to refer a patient with complex medical conditions and/or physical needs for a screening and assessment for consideration of acceptance into the Special Patient Clinic at the School of Dentistry. This form DOES NOT guarantee that the referred patient will be accepted as a patient for our teaching clinics.

If the patient has an appointed legal guardian or medical power of attorney, these are both REQUIRED for the initial assessment visit:

1. A copy of legal guardianship/medical power of attorney documents for our records.

2. The legal guardian/representative must accompany the patient to their initial assessment visit to discuss the patient's medical history, special care needs, dental findings, treatment recommendations and consent to the accepted treatment plan.

If these requirements are not met, it will result in delays in scheduling or the appointment will be rescheduled to a future date.

INSTRUCTIONS:
Please complete the following pages by entering the patient's information and medical conditions as well as your referral information. Incomplete referrals will be voided. You have several options to submit your referral:

- Electronically through our Secure Portal
  1. Email us for instructions at: dentalrecords@uth.tmc.edu
  2. Provide us with the name of your office in the email
  3. Response to your email will include instructions
  4. A separate email will be sent with link to our secure portal

- Fax to 713-486-4322

- Mail to address:
  UTHealth School of Dentistry
  ATTN: HIM
  RE: MDF
  7500 Cambridge, Suite 1310
  Houston, TX 77054

Thank you for referring your patient. If you have any questions, please contact our clinic at 713-486-4296.

UTHealth | School of Dentistry
The University of Texas Health Science Center at Houston

Special Patient Clinic Medical Data Form

Attending Physician/Primary Care Provider

**** Please answer the questions below and print legibly. This is a medical screening questionnaire and requires a complete update by the patient's attending physician or primary care provider prior to the patient receiving comprehensive dental care. ****

Patient Information

Last Name: _____ **First Name:** _____ **Middle:** _____

Date of Birth: _____ **Sex:** ☐ Male ☐ Female ☐ Transgender

Primary Phone#: _____ ☐ Home ☐ Work ☐ Mobile ☐ Other: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact Information

Last Name: _____ **First Name:** _____ **Middle:** _____

Phone#: _____ **Other#:** _____

Relation: *(Select one)* ☐ Child ☐ Guardian ☐ Parent ☐ Sibling ☐ Spouse ☐ Other

Medical Conditions

Please indicate if the patient has (or have had) any of the following diseases, problems, or symptoms and provide details, as applicable, such as severity and how well the conditions are controlled.

Cardiovascular System: ☐ None

☐ Atrial Fibrillation ☐ CHF ☐ Heart Murmur ☐ Mitral Valve Prolapse ☐ Stroke

☐ CAD ☐ DVT ☐ HTN ☐ Pacemaker

☐ Cardiac Arrhythmia ☐ Heart Attack ☐ Infective Endocarditis ☐ Cardiac Arrhythmia

☐ Other: _____

_____

Renal/GI Systems: ☐ None

☐ Cirrhosis/Liver Disease ☐ Crohn's Disease ☐ Hepatitis/Jaundice

☐ Colitis ☐ GERD ☐ Renal Disease:

☐ Hemodialysis or ☐ Peritoneal Dialysis

☐ Other: _____

_____

Respiratory System: ☐ None

☐ Asthma ☐ COPD/Bronchitis ☐ Pneumonia ☐ Tuberculosis

☐ Other: _____

Muscular/Skeletal System: ☐ None

☐ Arthritis ☐ Gout ☐ Motor Disabilities ☐ Osteoporosis

☐ Other: _____

_____

Endocrine System: ☐ None

☐ Diabetes ☐ Thyroid Disorder ☐ Other: _____

Immunologic System: ☐ None

☐ Autoimmune Disorder ☐ Organ Transplant ☐ Other: _____

Neurologic/Psychiatric System: ☐ None

☐ Alzheimer's Disease ☐ Autism ☐ Cerebrospinal Shunt ☐ Communication Disorders ☐ Depression

☐ Anxiety Disorder ☐ Cerebral Palsy ☐ CNS Disorder ☐ Dementia ☐ Parkinson's Disease

☐ Seizure/Epilepsy (Type and last occurrence): _____

☐ Other: _____

_____

Oncologic System: ☐ None

☐ Cancer or Neoplasia (Type and location): _____

☐ Chemotherapy ☐ Radiation (Amount): _____ ☐ Steroid Therapy

☐ Other: _____

_____

Hematologic System: ☐ None

☐ Bleeding Disorder

☐ Hemophilia A ☐ Idiopathic Thromobcytopenia Purpura (ITP) ☐ Von Willebrand Disease

☐ Hemophilia B ☐ Medication Induced

☐ Other: _____

_____

Other:

Medications

List of all current medications and herbal supplements.

****Attach for more****

Name:	Dose: (mg)	Frequency:	For what condition?

UTHealth | School of Dentistry
The University of Texas Health Science Center at Houston

Special Patient Clinic Medical Data Form

Additional Information

1. Any drug allergies? ☐ No ☐ Yes
   If yes, please explain: _____

_____

_____

2. Patient's Mobility Status: ☐ Ambulant ☐ Stretcher/Bed Patient ☐ Wheelchair

3. What is your medical evaluation with regard to the patient's ability to undergo oral health care that may include dental cleaning, restorations, root canals, and/or oral surgery under local anesthesia? (may include use of nitrous oxide)

_____

_____

_____

4. Do you anticipate the patient needing oral sedation/IV sedation for dental treatment? ☐ No ☐ Yes

5. Do you recommend antibiotic pre-medication prior to dental treatment? ☐ No ☐ Yes
   If yes, please explain the condition, reason, type, and dosage: _____

_____

_____

6. Does the patient have a legal guardian or medical power of attorney? ☐ No ☐ Yes
   If yes, please provide legal guardian/representative's name and attach any supporting documentation on file:

_____

Referring Physician

Provider's Name: _____

Specialty: _____

Entity: _____

Phone: _____ **Fax:** _____

Email: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Provider's Signature: _____ **Date:**_____