Therametric Technologies, Inc.
Adult Demographic & Medical-Dental History Form

This section is to be completed by TTI:

Subject Initials: _____ **Initial Form Completion Date: _____**
F M L **(dd mmm yyyy)**

PLEASE PRINT ALL INFORMATION LEGIBLY

DEMOGRAPHIC INFORMATION

Please complete the following (all information is kept confidential):

NAME: _____
(first) (middle initial) (last)

ADDRESS: _____

EMAIL ADDRESS: _____

By providing phone numbers below, you are giving TTI permission to call you regarding important study information.

Ok to leave voicemail?

HOME PHONE #: ..... (_____) _____-_____ ☐ YES ☐ NO
area code

WORK PHONE #: ..... (_____) _____-_____ ☐ YES ☐ NO
area code

CELL PHONE #: ..... (_____) _____-_____ ☐ YES ☐ NO
area code

OTHER #: (specify: _____) (_____) _____-_____ ☐ YES ☐ NO
area code

IS IT OK TO TEXT STUDY REMINDERS TO YOUR CELL PHONE? ☐ YES ☐ NO

- *If yes, a Study Contact Consent Form should be completed/signed and on file with the site.*

This section is to be completed by TTI:

CHANGE OF ADDRESS:
New Address: _____
Date Recorded: _____ Staff Initials: _____

CHANGE OF ADDRESS:
New Address: _____
Date Recorded: _____ Staff Initials: _____

CHANGE OF PHONE #:
New Phone #: (_____) _____-_____ Specify: HOME WORK CELL OTHER
area code circle one
Date Recorded: _____ Staff Initials: _____

CHANGE OF PHONE #:
New Phone #: (_____) _____-_____ Specify: HOME WORK CELL OTHER
area code circle one
Date Recorded: _____ Staff Initials: _____

This section is to be completed by TTI:

Subject Initials: _____

DEMOGRAPHIC INFORMATION CONT'D

GENDER: ☐ Male ☐ Female

ETHNICITY: ARE YOU OF HISPANIC ORIGIN? ☐ NO - Non-Hispanic/Non-Latino ☐ YES - Hispanic/Latino

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RACE:

☐ African-American

☐ American Indian/Alaska Native (optional – tribe can be specified:_____)

☐ Caucasian

☐ Native Hawaiian or Other Pacific Islander

☐ Asian (optional – origin can be specified: _____)

☐ Other (describe): _____

If Bi- or Multi-Race, please specify category: _____

(Example: Bi- or Multi-Racial categories could be: Creole, Mestizo, etc.)

DATE OF BIRTH: ____/____/_____ **AGE AT TIME OF DOCUMENT COMPLETION:** _____
(Month) (Day) (Year)

OCCUPATION: _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name: _____ **Relationship:** _____

Phone #: (_____) _____-_____
area code

This section is to be completed by TTI:

Additional Information/Changes: _____

_____

_____

_____

Date Recorded: _____ Staff Initials: _____

Additional Information/Changes: _____

_____

_____

_____

Date Recorded: _____ Staff Initials: _____

Additional Information/Changes: _____

_____

_____

_____

Date Recorded: _____ Staff Initials: _____

Initial Form Completed: _____
YYYY

This section is to be completed by TTI:

Subject Initials: _____

MEDICAL & DENTAL INFORMATION

It is important that you answer these questions correctly and to the best of your knowledge. During your study visits, you may be asked some questions about your responses to this questionnaire and you may be asked additional questions concerning your health. **If you have any changes in your health or medications during a study, please inform the study coordinator or dentist at your next study appointment.**

Height: _____ Weight: _____

1. Have there been changes in your health within the past year? …….. **Yes No**
If so, what changes have occurred? _____
_____

2. Are you now under the care of a physician? ……..... **Yes No**
If so, what condition(s) are being treated? _____
_____

3. My last physical exam was on: _____

4. The name and address of my physician is: _____
_____

5. Have you had a serious illness, operation, or have you been hospitalized in the past 5 years? ……..…… **Yes No**
If so, describe the illness/problem: _____

6. Are you taking any medications, including non-prescription drugs? …… **Yes No**
- If you answered **Yes**, you will be asked to complete the Medication and Supplement Profile at the end of this form (page 7).

7. Do you have or have you had any of the following diseases, conditions, problems, or procedures:

a. Abnormal bleeding? …….. **Yes No**
b. Blood transfusion? …… **Yes No**
c. AIDS or HIV infection? …… **Yes No**
d. Alcoholism? …… **Yes No**
e. Arthritis or painful swollen joints? ..... **Yes No**
f. Asthma?…… …….. **Yes No**
g. Artificial joint(s)?…….. **Yes No**
h. Blood disorders such as anemia? ..... **Yes No**
i. Cancer? …….. **Yes No**
j. Cardiovascular disease (such as heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, or stroke)? ……... **Yes No**

If so: **1.** Do you have chest pain upon exertion? …….. **Yes No**
2. Are you ever short of breath after mild exercise or when lying down? …… **Yes No**

Initial Form Completed: _____
YYYY

This section is to be completed by TTI:

Subject Initials: _____

3.	Do your ankles swell?	**Yes**	**No**
4.	Do you have heart defects present from birth?	**Yes**	**No**
5.	Do you have a cardiac pacemaker?	**Yes**	**No**
k.	Damaged/irregular/or artificial heart valves, Rheumatic Heart Disease, or any defect that has caused an abnormal heart murmur?	**Yes**	**No**
l.	Diabetes?	**Yes**	**No**
m.	Drug Addiction?	**Yes**	**No**
n.	Environmental or seasonal allergies?	**Yes**	**No**
o.	Epilepsy or other nervous system disease?..	**Yes**	**No**
p.	Fainting spells or seizures?	**Yes**	**No**
q.	Hepatitis, jaundice, or liver disease?	**Yes**	**No**
r.	High cholesterol?	**Yes**	**No**
s.	Kidney disease or dysfunction?.	**Yes**	**No**
t.	Low blood pressure?	**Yes**	**No**
u.	Low blood sugar?	**Yes**	**No**
v.	Persistent cough or cough that produces blood?	**Yes**	**No**
w.	Persistent swollen glands in neck?	**Yes**	**No**
x.	Persistent diarrhea or recent weight loss?	**Yes**	**No**
y.	Phenylketonuria (PKU); also known as Phenylalanine Hydroxylase Deficiency?	**Yes**	**No**
z.	Problems of the immune system?	**Yes**	**No**
aa.	Problems with mental health?..	**Yes**	**No**
bb.	Radiation therapy?	**Yes**	**No**
cc.	Respiratory problems, emphysema, bronchitis, etc.?.....	**Yes**	**No**
dd.	Sexually transmitted disease?	**Yes**	**No**
ee.	Sinus trouble?	**Yes**	**No**
ff.	Spinal Bifida or other conditions affecting the spine?	**Yes**	**No**
gg.	Stomach ulcer or acid reflux?	**Yes**	**No**
hh.	Thyroid problems?	**Yes**	**No**
ii.	Tuberculosis?	**Yes**	**No**
jj.	Tumor or growths?	**Yes**	**No**

If any of the conditions listed on page 3 or 4 are circled, or if you have (or have had) another condition not listed, please complete the following:

		Is the Condition……		
Condition:	**Date Diagnosed:**	**Ongoing?**	**Controlled?**	**Resolved?**
_____	_____	☐ Ongoing	☐ Controlled	☐ Resolved as of: _____
_____	_____	☐ Ongoing	☐ Controlled	☐ Resolved as of: _____
_____	_____	☐ Ongoing	☐ Controlled	☐ Resolved as of: _____
_____	_____	☐ Ongoing	☐ Controlled	☐ Resolved as of: _____
_____	_____	☐ Ongoing	☐ Controlled	☐ Resolved as of: _____
_____	_____	☐ Ongoing	☐ Controlled	☐ Resolved as of: _____

Initial Form Completed: _____
YYYY

This section is to be completed by TTI:

Subject Initials: _____

8. Are you allergic or have you had a reaction to:

a. Local anesthetics? ..... **Yes** **No**

b. Penicillin or other antibiotics? ..... **Yes** **No**

c. Sulfa drugs? ..... **Yes** **No**

d. Barbiturates, sedatives, or sleeping pills? ..... **Yes** **No**

e. Aspirin? ..... **Yes** **No**

f. Iodine? ..... **Yes** **No**

g. Codeine or other narcotics? ..... **Yes** **No**

h. Latex? ..... **Yes** **No**

i. Artificial sweeteners (such as aspartame, phenylalanine, xylitol, etc.)?.. **Yes** **No**

j. Cosmetic ingredients? ..... **Yes** **No**

k. Other (if yes, please list below) ..... **Yes** **No**

<u>If you circled 'YES'</u>: If you are allergic or have had a reaction to 1 or more substances, please provide the name(s) of the allergen (the substance that caused the allergic reaction) and describe your reaction(s) below:

Allergen:	**Reaction:**
_____	_____
_____	_____
_____	_____

9. Are you routinely prescribed an antibiotic prior to dental visits? ..... **Yes** **No**

10. Are you currently a tobacco user? ..... **Yes** **No**

If you answered yes, please complete the following questions:

Type: ☐ Cigarette ☐ E-Cigarette ☐ Cigar ☐ Pipe tobacco ☐ Smokeless tobacco

Amount: _____ Number of Years as a tobacco user: _____

11. Are you a former tobacco user? ..... **Yes** **No**

If you answered yes, please complete the following questions:

Type: ☐ Cigarette ☐ E-Cigarette ☐ Cigar ☐ Pipe tobacco ☐ Smokeless tobacco

Amount: _____ Number of Years as a tobacco user: _____

12. Women only: Are you pregnant or nursing? ..... **Yes** **No**

Do you expect to become pregnant within the next year?..... **Yes** **No**

Initial Form Completed: _____
YYYY

This section is to be completed by TTI:

Subject Initials: _____

Dental History

13. When was your last dental visit? _____ Dental cleaning? _____

14. Typically, how often do you see your dentist for a routine exam? _____

15. Typically, how often do you see your dentist/hygienist for a cleaning? _____

16. How often do you brush? _____ Floss? _____

17. Have you had one or more fillings in the last three years? …….. **Yes** **No**

18. Has anyone in your family ever had a lot of cavities develop in a short amount of time (3 or more in a year)? …….. **Yes** **No**

19. Have you had treatment for periodontal (gum) disease? ……. **Yes** **No**

If so, how long ago? _____

Is the condition resolved or ongoing?_____

20. Do you have a family history of periodontal disease? ……. **Yes** **No**

21. Have you had orthodontic braces? ……. **Yes** **No**

22. Have you ever had oral surgery? ……. **Yes** **No**

23. Have you had any dental implants placed? …….. **Yes** **No**

24. Have you been treated for temporomandibular disorder (TMJ)?..... **Yes** **No**

25. Do you wear dentures? …….. **Yes** **No**

If you answered yes, please indicate: ☐ ***Full Denture*** *OR* ☐ ***Partial Denture***

26. Do you wear a nightguard or any orthodontic appliance? …….. **Yes** **No**

Do you have consistent problems with any of the following:

27. Dry mouth/excessive thirst? ……. **Yes** **No**

28. Sensitive teeth? …….. **Yes** **No**

If so, what bothers you: ☐ Hot ☐ Cold ☐ Pressure ☐ Sweets

29. Mouth odors or bad taste? ……. **Yes** **No**

30. Cold sores, blisters, canker sores, or oral lesions? …….. **Yes** **No**

31. Sore, bleeding gums? ……. **Yes** **No**

32. Loose teeth? ……. **Yes** **No**

33. Difficulty Chewing? ……. **Yes** **No**

34. Teeth or fillings break frequently? ……. **Yes** **No**

35. Clenching or grinding habits? ……. **Yes** **No**

36. Jaw pain? ……. **Yes** **No**

37. Jaw popping, clicking, or snapping? ……. **Yes** **No**

This section is to be completed by TTI:

Subject Initials: _____

If you answered 'Yes' to question #6 on page 3, please complete the table below:

MEDICATION AND SUPPLEMENT PROFILE

List all vitamins, supplements, prescription, and over-the-counter medications with the dosage and frequency taken within the last 6 months:

Drug Name	Dose	Frequency	Date Start	Date Stopped	Reason for Taking

Note: All known information regarding medications and supplements must be listed in this section.

I HAVE ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY ABILITY:

_____
Printed Name of Adult Subject

_____ _____
Signature of Adult Subject Date

SUBJECTS STOP HERE. THE NEXT PAGES ARE UPDATES FOR SUCCESSIVE STUDIES

_____
Printed Name of Study Personnel Conducting the Original Medical/Dental History Review

_____ _____
Signature of Study Personnel Conducting the Original Medical/Dental History Review Date

TTI Personnel: Check here if a revised Medication and Supplement Profile has been added: ☐

Initial Form Completed: _____
YYYY

This section is to be completed by TTI:

Subject Initials: _____

Medical/Dental History Updates

This page MUST be signed upon review at each successive study start.

Please explain any updates/changes below. If there have NOT been any changes since your last study participation, please skip to the 'NO CHANGE' section at the bottom of this page.

Update 1: If your physician or dentist has diagnosed (or if you have noticed) any new health or dental problems since your last study appointment with TTI, please list the changes below:

_____

_____

_____

_____

_____

Other than the above listed medical/dental update, all other information initially provided is still current/correct:

_____	_____	_____	_____
Signature of Adult Subject	Signature Date	Study Staff Initials	Date Reviewed

Update 2: If your physician or dentist has diagnosed (or if you have noticed) any new health or dental problems since your last study appointment with TTI, please list the changes below:

_____

_____

_____

_____

_____

Other than the above listed medical/dental update, all other information initially provided is still current/correct:

_____	_____	_____	_____
Signature of Adult Subject	Signature Date	Study Staff Initials	Date Reviewed

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NO CHANGE: If there have NOT been any new health or dental problems/changes since your last study participation with TTI, please sign and date below. Your dated signature indicates that there have been no changes since your last review and that the information contained in this document is currently up-to-date/accurate.

_____	_____	_____	_____
Signature of Adult Subject	Signature Date	Study Staff Initials	Date Reviewed
_____	_____	_____	_____
Signature of Adult Subject	Signature Date	Study Staff Initials	Date Reviewed
_____	_____	_____	_____
Signature of Adult Subject	Signature Date	Study Staff Initials	Date Reviewed
_____	_____	_____	_____
Signature of Adult Subject	Signature Date	Study Staff Initials	Date Reviewed

Please Note: Supplemental page(s) of page 8 may be added as necessary.

Initial Form Completed: _____
YYYY

This section is to be completed by TTI:

Subject Initials: _____

IF needed, please complete a revised Medication and Supplement Profile:

Date Updated: ____/____/_____
(Month) (Day) (Year)

MEDICATION AND SUPPLEMENT PROFILE

List all vitamins, supplements, prescription, and over-the-counter medications with the dosage and frequency taken within the last 6 months:

Note: All known information regarding medications and supplements must be listed in this section.

Drug Name	Dose	Frequency	Date Start	Date Stopped	Reason for Taking

Please Note: Supplemental page(s) of page 9 may be added as necessary.

Initial Form Completed: _____
YYYY