DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

BUMEDINST 6600.12
BUMED-631
19 Apr 93

BUMED INSTRUCTION 6600.12

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Dental Personnel

Subj: NAVMED 6600/3, DENTAL HEALTH QUESTIONNAIRE

Ref: (a) MANMED art. 6-121B
(b) MANMED art. 6-100A
(c) NAVMEDCOMINST 6150.1

Encl: (1) Sample Completion of NAVMED 6600/3

1. Purpose. To issue guidance for use of the revised Dental Health Questionnaire, NAVMED 6600/3 (enclosure (1)).

2. Cancellation. NAVMEDCOMINST 6600.2.

3. Scope. Applies to dental health care providers in all Navy and Marine Corps medical and dental treatment facilities (MTFs and DTFs), both ashore and afloat.

4. Background. The health and physical status of dental patients must be determined before rendering any dental care. This is essential to protect not only the dental patients' well-being, but also that of other patients and staff personnel. The documentation of health status is an important element of the medico-legal record of dental care.

5. Action

a. Hold reference (a) in abeyance.

b. Dental officers, civilian dentists, and auxiliary personnel providing direct patient care must ensure that each patient has a completed, up-to-date Dental Health Questionnaire in their dental treatment record (NAVMED 6150/10 through 19), before performing an examination or providing dental treatment. The NAVMED 6600/3 must be filled out and signed by each patient. This must be reviewed, dated, and signed by the first dental officer who conducts the examination or dental treatment. For minors, i.e., under the age of consent or majority in the applicable jurisdiction, the parent or guardian must fill out the form and sign in the patient's signature block of the questionnaire, using his or her name and not the child's name.

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c. Each dental care provider must indicate, in box 10 of the SF 603 or SF 603A, that the questionnaire has been reviewed and updated by the patient, using the following dated and signed entry: "HQR dtd (date) (findings)." The "findings" could be "within normal limits (WNL)," or could be significant items which affect the treatment provided. It is not essential to restate all positive responses on the NAVMED 6600/3 unless pertinent to the treatment at hand. For example: (1) HQR dtd 7 Jun 92 (Heart murmur - SBE prophylaxis indicated). (2) The "HQR" entry must be placed in the objective data, "O" section of the "S.O.A.P." treatment plan for examinations or consultations (reference (b)), or as the first item of each entry documenting patient treatment.

d. During annual dental exams, patients need only to review, date, and sign the current questionnaire if health status has not changed.

e. Whenever a significant change in medical history or health status occurs, a new questionnaire must be filled out, dated, and signed.

f. The initial and all later Dental Health Questionnaires must be permanently maintained in the Treatment Record (Dental), per reference (c).

g. For conditions which require medical clarification use the SF 513, (Consultation Sheet). Document the consultation in the SF 603 or 603A and in the summary of pertinent findings section of the NAVMED 6600/3.

6. Forms

a. NAVMED 6600/3 (Rev. 1-92), Dental Health Questionnaire, S/N 0105-LF-013-7700; SF 603 (10-75), Health Record - Dental, S/N 0105-LF-011-9300; and SF 603A (10-75), Health Record - Dental (Continuation), S/N 0105-LF-011-9400, are available from the Navy Supply System and may be requisitioned per NAVSUP P-2002D.

b. SF 513 (9-77), Medical Record - Consultation Sheet, NSN 7540-00-634-4127, is available from the Federal Supply System through normal supply procurement procedures.

D. F. HAGEN

Stocked:
Naval Publications and Forms Directorate
Physical Distribution Division Code 103
5801 Tabor Ave.
Phila., PA 19120-5099

SAMPLE COMPLETION OF NAVMED 6600/3

1. Patients shall review the questionnaire; and then, enter data, circle or check appropriate items, and sign the form.
2. The shaded portion is reserved for use by dental staff.

DENTAL HEALTH QUESTIONNAIRE | Personal Data - Privacy Act of 1974 | BUMEDINST 6600.12

My Chief Complaint or Reason for this Examination is: ANNUAL EXAM NO COMPLAINTS

HAVE YOU EVER HAD OR HAVE YOU NOW: *(Please check at the Right of each item)*

(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW
Epilepsy or Seizures		✓		Hemophilia		✓		Ulcers		✓	
Fainting or Dizziness		✓		Bruise or Bleed easily		✓		Kidney problems		✓	
Nervousness		✓		Heart problems or Angina		✓		Venereal disease		✓	
Stroke		✓		Hypertension		✓		Diabetes		✓	
Glaucoma		✓		Rheumatic fever		✓		Thyroid disease		✓	
Cold sores (Herpes)		✓		Heart murmur	✓			HIV +		✓	
Persistent cough		✓		Mitral valve prolapse		✓		Arthritis		✓	
Emphysema		✓		Congenital heart lesions		✓		Painful joints (incl. jaw)		✓	
Tuberculosis/PPD positive		✓		Heart surgery		✓		Prosthetic joint(s)		✓	
Asthma		✓		Prosthetic heart valve(s)		✓		Hives		✓	
Hay fever		✓		Pacemaker		✓		Steroid medication(s)		✓	
Sinus problems		✓		Blood transfusion(s)		✓		Drug addiction		✓	
Anemia		✓		Liver disease		✓		Alcoholism		✓	
Sickle cell disease		✓		Yellow jaundice		✓		Unexplained weight change		✓	
G-6PD deficiency		✓		Hepatitis- type:		✓		Cancer/radiation		✓	

1. Have you ever been told that you should not donate blood? ✓
2. Have you ever been told that you need antibiotics before dental treatment? ✓
3. Females: Are you taking birth control pills (BCPs)?
   Are you or might you be pregnant? (Estimated delivery)
   Are you breast feeding at the present time? ✓
4. Do you have a disease, condition, or problem not listed above? ✓
   If Yes, Please Describe:

INSTRUCTIONS: Please answer the following questions by circling, and if applicable by entering the appropriate response: If yes, describe - If no, please write "no/none"

1. Are You In: Flight Status? . . Yes (No) / Personnel Reliability Program? YES (NO)
2. Are You Presently Ill Or Under The Care Of A Physician YES (NO)
   If Yes, Please Describe:
   History Of Hospitalizations:
   (Including Cancer Treatment)
3. Any Allergies? (Including Rubber) None
4. Medications Presently Taking: None
   (including aspirin, etc.)

Any Family History Of: (Circle)
Heart Disease Cancer
(Diabetes) Seizures

Your Social History:
- Type and frequency of:
- Tobacco use: (age started?) Don't smoke
- Alcohol consumption: 1-2 beers on weekend

Occupation/Jobs: RM3

Patient's Signature	Date	Dental Officer's Signature	Date
John Q. Doe	3 Feb 1993	G. V. Black	3 Feb 1993

SUMMARY OF PERTINENT FINDINGS/RECOMMENDED TREATMENT MODIFICATIONS: *(Dentist's use only)*

Patient's mother told him he had a heart murmur. SF 513 from medical states normal heart function and no indication for pre-medication.

Shaded Portion

PATIENT'S IDENTIFICATION *(Use Space for Mechanical Imprint)*

Patient's Name *(Last, First, Middle initial)*	SEX
DOE, JOHN Q.	M

DATE OF BIRTH	RELATIONSHIP TO SPONSOR	COMPONENT/STATUS	DEPART/SERVICE
3SEP68			

SPONSOR'S NAME	Rank/Grade
	RM3

SSN OR IDENTIFICATION NO.	ORGANIZATION
111-11-1111	US NAVY

NAVMED 6600/3 (REV 1-92)

S/N 0105-LF-013-7700

Entry of patient identification data may be either imprinted or printed in ink.