PRACTICAL CLINICAL COURSES

A Service of the Gordon J. Christensen
Career Development Program

V3902
Preparing for Your Next Medical Emergency, 3rd Edition

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Materials Included

C.E. Instruction Sheet
Products List
ADA Health History Form
Clinicians Responsible
Goals & Objectives
Overview
References
AGD Post-Test

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PROCEDURE FOR RECEIVING ACADEMY OF GENERAL DENTISTRY AND STATE CREDIT FOR CE VIDEOS

1. Complete the enclosed Post-Test.* For each **CE Video Purchased,** one test is included. If additional tests are needed, the following fees will apply: $25 per test for 1 additional dentist; $10 per test for each auxiliary (dental assistants, hygienists, lab technicians - no limit on auxiliary tests). Fees can be paid either by check or credit card when tests are submitted to Practical Clinical Courses.

2. Complete the demographic information located at the end of the test.
   Type of Credit:
   a. If the applicant selects "AGD," PCC will send notification to both the applicant and the Academy of General Dentistry. (The AGD will also notify applicant of credits earned by printout information.)

   b. If the applicant selects "State," PCC will send a certificate of verification to the applicant. The applicant must then submit this certificate to his/her state board to obtain credit.

   c. If the applicant selects "Both," PCC will complete a. & b. above.

3. Return the **Post-Test portion** via mail, fax, or email. Our contact information is as follows:

Practical Clinical Courses
3707 N Canyon Road
Suite 3D
Provo, UT 84604
Fax: (801) 226-8637
info@pccdental.com

4. Practical Clinical Courses will correct the Post-Test. **Passing scores are 70% or higher.**

***TO OBTAIN CE CREDIT ONLINE**: Login or create an account on www.pccdental.com and select "My CE Tests" from the left-side menu. Click on the video title to take the test online. **RESULTS ARE IMMEDIATE**. Missing the test? C*ontact us at 800-223-6569 during our business hours of 7:00 a.m. – 5:00 p.m. MST to add it to your account.

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Sources of Products Discussed in

V3902 Preparing for Your Next Medical Emergency, 3rd Edition

Presented by: David M. Anderson, DDS, MD & Gordon J. Christensen, DDS, MSD, PhD

1. **AED Plus Unit**
   ZOLL Medical Corporation
   269 Mill Road
   Chelmsford, MA 01824-4105
   (800)348-9011
   (978)421-9655
   www.zoll.com

2. **Ambu Bag**
   Local Medical Supply Company

3. **Basic Emergency Medical Kits**
   HealthFirst
   11629 49th Place West
   Mukilteo, WA 98275
   (800)331-1984
   (425)771-5733
   www.healthfirst.com

4. **Criticare Monitor 506**
   Salvin Dental Specialties
   3450 Latrobe Drive
   Charlotte, NC 28211
   (800)535-6566
   (704)442-5400
   www.salvin.com

5. **Criticare N-Genuity**
   Salvin Dental Specialties
   3450 Latrobe Drive
   Charlotte, NC 28211
   (800)535-6566
   (704)442-5400
   www.salvin.com

6. **Intellisense Professional Digital Blood Pressure Monitor**
   Omron Healthcare, Inc.
   1925 West Field Court
   Lake Forest, IL 60045
   (800)634-4350
   (847)680-6200
   www.omronhealthcare.com

7. **Stat Kit 550 Emergency Medical Kit**
   HealthFirst
   11629 49th Place West
   Mukilteo, WA 98275
   (800)331-1984
   (425)771-5733
   www.healthfirst.com

Product names, the products themselves, and company names change rapidly. Please contact the companies shown to confirm current information.

Gordon J. Christensen Practical Clinical Courses, 3707 North Canyon Road, Suite 3D, Provo, UT 84604
Toll Free (800) 223-6569 or Utah Residents (801) 226-6569

Health History Form

ADA American Dental Association®
America's leading advocate for oral health

Email: Today's Date:

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *Last* *First* *Middle*
Home Phone: *Include area code* ( )
Business/Cell Phone: *Include area code* ( )

Address: *Mailing address*
City: State: Zip:

Occupation: Height: Weight: Date of Birth: Sex: M F

SS# or Patient ID: Emergency Contact: Relationship: Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*

	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *Please mark (X) your responses to the following questions.*

	Yes	No	DK
Do your gums bleed when you brush or floss?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Is your mouth dry?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐	☐
Is your home water supply fluoridated?	☐	☐	☐
Do you drink bottled or filtered water?	☐	☐	☐
If yes, how often? (*Check one:*) DAILY ☐ / WEEKLY ☐ / OCCASIONALLY ☐			
Are you currently experiencing dental pain or discomfort?	☐	☐	☐

	Yes	No	DK
Do you have earaches or neck pains?	☐	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐	☐
Do you brux or grind your teeth?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐
Do you wear dentures or partials?	☐	☐	☐
Do you participate in active recreational activities?	☐	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐	☐

Date of your last dental exam:
What was done at that time?

Date of last dental x-rays:

What is the reason for your dental visit today?

How do you feel about your smile?

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐

Physician Name: Phone: *Include area code* ( )

Address/City/State/Zip:

	Yes	No	DK
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐

If yes, what condition is being treated?

Date of last physical exam:

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐

If yes, what was the illness or problem?

	Yes	No	DK
Are you taking or have you recently taken any prescription or over the counter medicine(s)?	☐	☐	☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)

	Yes	No	DK
Do you wear contact lenses?	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use controlled substances (drugs)?	☐	☐	☐
Do you use tobacco (smoking, snuff, chew, bidis)? If so, how interested are you in stopping? *Circle one:* VERY / SOMEWHAT / NOT INTERESTED	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

Allergies. Are you allergic to or have you had a reaction to:
To all **yes** responses, specify type of reaction.

	Yes	No	DK
Local anesthetics _____	☐	☐	☐
Aspirin _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (rubber) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Animals _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion If yes, date: _____	☐	☐	☐
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Eating disorder	☐	☐	☐
Malnutrition	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders If yes, specify: _____	☐	☐	☐
Sleep disorder	☐	☐	☐
Do you snore?	☐	☐	☐
Mental health disorders Specify: _____	☐	☐	☐
Recurrent Infections Type of infection: _____	☐	☐	☐
Kidney problems	☐	☐	☐
Night sweats	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Severe or rapid weight loss	☐	☐	☐
Sexually transmitted disease	☐	☐	☐
Excessive urination	☐	☐	☐

	Yes	No	DK
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?	☐	☐	☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

	Yes	No	DK
Do you have any disease, condition, or problem not listed above that you think I should know about? Please explain:	☐	☐	☐

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

PROGRAM

V3902 Preparing for Your Next Medical Emergency, 3rd Edition

CLINICIANS RESPONSIBLE:

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Assistant Professor & Director of Oral & Maxillofacial Surgery
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CEO, Practical Clinical Courses
CEO, CR Foundation
Practicing Prosthodontist, Provo, Utah

GOALS & OBJECTIVES

At the completion of this video presentation, viewers should be able to:

1. Discuss adequate medical history questionnaire content.
2. Discuss physical evaluation needs.
3. List and discuss the American Society of Anesthesiologists (ASA) classification of patients.
4. Discuss the need to consult with other practitioners on specific patient treatments.
5. Discuss the relative percentage of occurrence of typical medical emergencies in dental offices.
6. List the signs, symptoms, and treatment for syncope.
7. List the signs, symptoms, and treatment for an allergic reaction.
8. List the signs, symptoms, and treatment for anaphylactic shock.
9. List the signs, symptoms, and treatment for postural hypotension.
10. List the signs, symptoms, and treatment for a seizure.
11. List the signs, symptoms, and treatment for asthmatic attack.
12. List the signs, symptoms, and treatment for bronchospasm.
13. List the signs, symptoms, and treatment for hyperventilation.
14. List the signs, symptoms, and treatment for epinephrine reaction.
15. List the signs, symptoms, and treatment for hypoglycemia and insulin shock.
16. List the signs, symptoms, and treatment for angina and myocardial infarction.
17. List the signs, symptoms, and treatment for stroke.
18. List the signs, symptoms, and treatment for aspirating an object.
19. List the major contents for a typical medical emergency kit.
20. Make suggestions for a typical staff educational session on medical emergencies.

OVERVIEW

V3902 Preparing for Your Next Medical Emergency, 3rd Edition

Although infrequently occurring, medical emergencies do occur in outpatient clinics, and they usually occur at very inconvenient times. This presentation is planned: (1) to show a demonstration of the signs and symptoms of typical medical emergencies that are known to occur in dental offices, (2) to pause for the viewers to determine what emergency they are observing, and (3) to discuss treatment for the emergency.
The following topics are included in this presentation:

- Medical history questionnaire content
- Physical evaluation needs
- The American Society of Anesthesiologists (ASA) classification of patients
- Need to consult with other practitioners on specific patient treatments
- The relative percentage of occurrence of typical medical emergencies in dental offices
- Signs, symptoms, and treatment for syncope
- Signs, symptoms, and treatment for an allergic reaction
- Signs, symptoms, and treatment for anaphylactic shock
- Signs, symptoms, and treatment for postural hypotension
- Signs, symptoms, and treatment for a seizure
- Signs, symptoms, and treatment for asthmatic attack
- Signs, symptoms, and treatment for bronchospasm
- Signs, symptoms, and treatment for hyperventilation
- Signs, symptoms, and treatment for epinephrine reaction
- Signs, symptoms, and treatment for hypoglycemia and insulin shock
- Signs, symptoms, and treatment for angina and myocardial infarction
- Signs, symptoms, and treatment for stroke
- Signs, symptoms, and treatment for aspirating an object
- List the major ingredients for a typical medical emergency kit
- Make suggestions for a typical staff educational session on medical emergencies

REFERENCES

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2. Al-Hassan M, AlQahtani S. Preparedness of dental clinics for medical emergencies in Riyadh, Saudi Arabia. Saudi Dent J. 2019 Jan;31(1):115-21. doi: 10.1016/j.sdentj.2018.11.006. Epub 2018 Nov 24.

3. Azad A, Deilami Z, Karimi A, Talattof Z, Zahed M. Knowledge and attitude of general dentists regarding common emergencies in dental offices: A cross-sectional study in Shiraz, Iran. Indian J Dent Res. 2018 Sep-Oct;29(5):551-5. doi: 10.4103/ijdr.IJDR_587_16.

4. Ragan MR, Rayner C. Are You Ready for Emergency Medical Services in Your Oral and Maxillofacial Surgery Office? Oral Maxillofac Surg Clin North Am. 2018 May; 30(2):123-35. doi: 10.1016/j.coms.2018.01.006.

5. Cardona CY, Gangula PR, Gill DG, Halpern LR, Mouton CP, Southerland JH. Dental management in patients with hypertension: challenges and solutions. Clin Cosmet Investig Dent. 2016 Oct 17; 8:111-20. eCollection 2016.

6. Barzani G, Dym H, Mohan N. Emergency Drugs for the Dental Office. Dent Clin North Am. 2016 Apr;60(2):287-94. doi: 10.1016/j.cden.2015.11.001.

POST-TEST

V3902 Preparing for Your Next Medical Emergency, 3rd Edition

1. It is suggested that ASA classifications _____ should be treated in dental offices.
   - ☐ a. 1-2
   - ☐ b. 1-3
   - ☐ c. 1-4
   - ☐ d. 1-6

2. It is suggested that ASA classifications _____ should be treated in hospitals.
   - ☐ a. 2-6
   - ☐ b. 3-6
   - ☐ c. 4-6
   - ☐ d. 5-6

3. Which is the most commonly occurring medical emergency in dental offices?
   - ☐ a. Postural hypotension
   - ☐ b. Asthmatic attack
   - ☐ c. Syncope
   - ☐ d. Angina

4. Hives; swelling of the lips, tongue, face; wheezing; and rapid pulse may indicate:
   - ☐ a. postural hypotension.
   - ☐ b. an allergic reaction.
   - ☐ c. an asthmatic attack.
   - ☐ d. syncope.

5. A patient stands up after being treated and faints. This is usually _____.
   - ☐ a. hyperventilation
   - ☐ b. stroke
   - ☐ c. hypoglycemia
   - ☐ d. postural hypotension

6. A patient who has confusion, uncontrollable jerking, fear, and staring has _____.
   - ☐ a. a stroke
   - ☐ b. a myocardial infarction
   - ☐ c. a seizure
   - ☐ d. insulin shock

7. A patient receiving dental treatment has unexpected pain and pressure in the chest. This usually indicates _____.
   - ☐ a. anaphylaxis
   - ☐ b. angina or myocardial infarction
   - ☐ c. a stroke
   - ☐ d. an epinephrine reaction

POST-TEST (CONT'D)

V3902 Preparing for Your Next Medical Emergency, 3rd Edition

8. A patient receiving dental treatment has wheezing when breathing, severe coughing, and difficulty talking. These conditions usually indicate _____.
   - ☐ a. an epinephrine reaction
   - ☐ b. an asthmatic attack
   - ☐ c. angina or myocardial infarction
   - ☐ d. a stroke

9. When a patient appears to have swallowed or aspirated an object, you need to check the following potential locations where it may now be located:
   - ☐ a. It could be in the digestive system – radiograph required.
   - ☐ b. It could be in the respiratory system – radiograph required.
   - ☐ c. It could have been aspirated by the high velocity suction system. Check the suction system.
   - ☐ d. All of the above.

10. It was suggested in this presentation that the best way to ensure that staff understand medical emergencies is to:
   - ☐ a. make a written list of the emergencies.
   - ☐ b. have frequent staff in-service education sessions and discuss the emergencies.
   - ☐ c. have staff read a book on the subject.
   - ☐ d. go to a course on medical emergencies.

PLEASE PRINT

Name_____

Name of video purchaser (if different from above) _____

Address_____

City/State/Zip_____

Phone No. _____

Email _____

Indicate which type of credit you wish to obtain: ☐ AGD ☐ State ☐ Both

State License No. _____ AGD No. _____

Payment information ☐ **Visa** ☐ **American Express** ☐ **Mastercard** ☐ **Discover**

Card # __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __ Expires __ __ / __ __ CVV2-Code: _____

The test is complimentary for the purchaser. *If you require CE tests for staff members or an additional doctor to receive credit, the fees are:*

Dentist (limit 1 additional dentist per video purchase): $25
Auxiliary (no limit): $10 for each auxiliary taking test