DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service
DENTAL PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: ____ - ____ - ____
Last Name First Name MI Month Day Year

Please complete this form so that we can better provide care for your oral health needs.

What is the purpose of your visit to our office today? _____

Do you have a toothache now? ☐ Yes ☐ No If yes, for how long? _____

On a scale of 0-10, with 10 being the most painful, what is your pain level today? _____

How confident are you filling out medical forms by yourself? (Check one)

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Extremely

If you are unsure of how to answer any of the questions, please ask the dental staff for help.

Please respond by circling the number that mostly closely answers	**Not At All**	**Several Days**	**Over Half the Days**	**Nearly Every Day**
Over the past 2 weeks, have you had little interest or pleasure in doing things?	0	1	2	3
Over the past 2 weeks, have you felt down, depressed, or hopeless?	0	1	2	3
Personal Safety				
Do you feel safe at home? ☐ Yes ☐ No Would you like to discuss your safety with a provider? ☐ Yes ☐ No				

Have you ever had any of the following conditions?	**Yes**	**No**	**Dates if known and short description**
Circulatory System			
Congenital heart disease, defect, or heart murmur?			
Heart disease or congestive heart failure?			
Heart attack?			
High blood pressure (hypertension)?			
Bacterial endocarditis?			
Chest pain or angina?			
Anemia or abnormal bruising or bleeding?			
Do you have a pacemaker, defibrillator, or other artificial heart device?			
Do you take blood thinners (e.g. Plavix, baby aspirin, Coumadin, warfarin)?			
Immune System			
Organ transplant or on organ transplant list?			
Spleen removed?			
Addison's or Cushing's disease, chronic steroid use (e.g. prednisone, etc.)			
HIV or AIDS, or do you believe you have been exposed?			
Lupus, rheumatoid arthritis, or any autoimmune condition?			
Irritable bowel syndrome, Crohn's disease, stomach ulcers, or gastric bypass?			
Cancer, tumors, chemotherapy, or radiation?			
Do you take medications that suppress your immune system (e.g. Remicade)?			
Excretory System			
Kidney problems, including dialysis?			
Hepatitis? If so, what type and is it currently active?			
Do you have any type of liver condition?			
Endocrine System			
Diabetes? If yes, what type?			
Thyroid problems of any kind? If yes, was it high or low thyroid?			
Do you take a thyroid medication (e.g. Synthroid, levothyroxine)?			
Nervous System			
Stroke?			
Epilepsy, seizures, multiple sclerosis or a nervous system disorder?			
Musculoskeletal System			
Osteoporosis or taken medicine for osteoporosis? Please list.			
Joint replacement (hip, knee, ankle, shoulder)?			
Osteoarthritis (i.e. degenerative arthritis)?			

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	Yes	No	Dates if known and short description
Respiratory System			
Asthma or chronic lung disease (e.g. emphysema, COPD, chronic bronchitis)?			
Tuberculosis, histoplasmosis, cystic fibrosis, blastomycosis?			
Reproductive System			
Sexually transmitted disease (STD)?			
WOMEN ONLY – Are you currently:			
Pregnant or potentially pregnant? ☐ Yes ☐ No If yes, how many weeks?			
Breastfeeding? ☐ Yes ☐ No Using birth control (other than physical barrier devices)? ☐ Yes ☐ No			
Substance Use			
(check all that apply) Do you: ☐ smoke ☐ chew tobacco ☐ vape ☐ use e-cigarettes ☐ traditional tobacco			
Aside from traditional tobacco use, would you like help quitting? ☐ Yes ☐ No			
To identify possible contraindications, do you use/consume any of the following ? ☐ alcohol ☐ marijuana ☐ other recreational drug			
In recovery or treatment for substance use?			
Have you been on a Pain Agreement or utilized Methadone or Suboxone?			
General Questions	**Yes**	**No**	**Dates if known and short description**
Do you have any physical or mental disability requiring special consideration?			
Experienced vertigo, dizziness, or fainting?			
Have you ever had any type of operation or surgery? If yes, please list.			
Have you ever been hospitalized? If yes, describe when and why.			
Any disease or condition not listed? If yes, please list.			
(check all that apply)			
Do you have **allergies or reactions** to any of the following: ☐ penicillin ☐ sulfa ☐ local anesthetics ☐ metal ☐ latex			
Do you have seasonal, food, or insect allergies, or any other sensitivities? ☐ yes ☐ no (If yes please list below)			
Please list other allergies/sensitivities: _____			

Please list **all medications** you currently take (include over-the-counter drugs and herbal supplements):

Medication Name	What is it for?	How often do you take it?	What dosage (mg, etc.)?

Date of last medical appointment? _____ - ____ - ____ Purpose of that appointment? _____
Month Day Year

Who is your primary care physician/provider? _____

Please carefully read the following statement and sign below.

The answers I have given above are true to the best of my knowledge. I am indicating my consent for routine diagnostic tests and procedures such as x-rays, cleaning, blood pressure, local anesthesia, fillings, crowns, and fluoride by signing below on behalf of myself or the above named minor in my guardianship.

Patient/Guardian Signature: _____ Date/Time: _____

Provider Signature: _____ Date/Time: _____

**********PROVIDER NOTES**********

Provider Name: _____ Patient Health Record Number: _____

Notes: _____

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