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

Please complete these two pages so that we can better provide care for your oral health problems. If you are unsure of how to answer any of the questions, please ask the dental staff for help.

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

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 1-10, with 10 being the most painful, what is your pain level today (write a number): ☐

Do you have or have you had any of the following conditions?

	Yes	No	If Yes, Please Describe (include dates, if known)
Circulatory System			
Do you have any congenital heart disease, defect, or heart murmur?			
Do you have, or have you ever had, heart disease or congestive heart failure?			
Have you ever had a heart attack?			
Do you have high blood pressure (hypertension)?			
Have you ever had bacterial endocarditis?			
Do you, or have you ever had, chest pain or angina?			
Have you had anemia or abnormal bruising or bleeding?			
Are you taking any blood thinners (Plavix, baby aspirin, etc.)? If so, which one?			
Do you have a pacemaker, defibrillator, or other artificial heart device?			
Immune System			
Have you ever had an organ transplant?			
Have you had your spleen removed?			
Are you on steroids (prednisone) or biological drugs (Humira) now?			
Do you have HIV or AIDS, or do you believe you have been exposed?			
Do you have lupus, rheumatoid arthritis, or any immune condition?			
Have you ever had cancer or tumors?			
Have you ever received, or are you now receiving, chemotherapy or radiation?			
Excretory System			
Have you ever had any kidney problems, including dialysis?			
Have you ever had hepatitis? If so, what type and is it currently active?			
Do you have any type of liver disease?			
Endocrine System			
Do you have diabetes, and if so, what type?			
Have you had thyroid problems of any kind? If so, was it high or low thyroid?			
Nervous System			
Have you ever had a stroke?			
Have you ever had epilepsy, seizures, or a nervous system disorder?			
Over the past 2 weeks, have you had little interest or pleasure in doing things?			
Over the past 2 weeks, have you felt down, depressed, or hopeless?			
Musculo-Skeletal System			
Do you have osteoporosis or taken medicine for osteoporosis?			
Have you ever had a joint replaced (hip, knee, ankle, shoulder)?			
Respiratory System			
Do you have asthma or any lung disease?			
Have you ever had tuberculosis?			

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	Yes	No	If Yes, Please Describe (include dates, if known)
Reproductive System			
Have you ever had a sexually transmitted disease (STD)?			
WOMEN ONLY: Are you currently pregnant? If yes, how many weeks?			
WOMEN ONLY: Are you currently nursing?			
WOMEN ONLY: Are you taking birth control?			
General Questions			
Do you have any physical or mental disability that requires special consideration?			
Have you ever experienced vertigo, dizziness, or fainting?			
Do you have any allergies to latex, iodine, red dye, food, medications? If so, list:			
Do you smoke or chew tobacco?			If yes, do you want to quit? _____
Have you ever had any type of operation or surgery? If so, please list.			
Have you ever been hospitalized? If yes, describe when and why.			
Are you allergic to any medications, or do any make you sick? If so, please list.			
Do you have any disease, condition, or problem not listed? If yes, please list.			

When was your last medical appointment? (please list date): _____ - _____ - _____
Month Day Year

What was the purpose of that appointment? _____

Who is your primary care physician/provider? _____

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

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

Please carefully read and sign the statement 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, and fluoride by signing below on behalf of myself or the above named minor in my guardianship.

Patient Signature: _____ Date/Time: _____

Provider Signature: _____ Date/Time: _____

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

Provider Name: _____ Patient Health Record Number: _____

Notes: _____

_____

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