DENTAL PATIENT MEDICAL HISTORY

PATIENT IDENTIFICATION

Name ____DOB: __________

Phone: Home______________ Work______________ Cell _________________

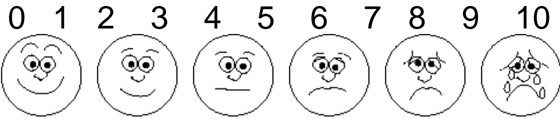
Mailing Address: ____

City: ______________________State: _________ZIP Code: _________________

~PROVIDER REVIEW~

(Date/Initials)	(Date/Initials)
______________	______________
______________	______________
______________	______________
______________	______________

0 1 2 3 4 5 6 7 8 9 10



Please mark the amount of pain you are in today by circling a number with "0" being no pain and "10" being severe pain or mark a face with an "X" to tell us how much pain you are in.

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

Do you have concerns about receiving dental treatment? No ❑ Yes ❑ (If yes, specify)___________________________

Has there been any change in your general health this past year? No ❑ Yes ❑

List any medication, prescribed or over the counter (pills or drugs) that you are currently taking:_______________________

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Are you taking any prescription medication prescribed outside of Sioux San IHS? (if yes, specify) ______________________

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Are you taking any over the counter drugs or herbal medicine? (if yes, specify)_____________________________________

(Please Check)	Yes	No	Have you ever had the following?	Yes	No
1. Have you received medical care in the past two years?			1. Asthma 2. Congenital Heart Disease		
2. Are you allergic to or made sick by any medicine? If yes, list:			3. Heart Attack or angina 4. Heart surgery / pacemaker / stents 5. Diabetes		
3. Do you use alcohol or other drugs?			6. High Blood Pressure		
If yes, do you want to quit?			7. Joint replacement		
4. Do you use tobacco products?			8. Stroke		
If yes, do you want to quit?			9. Ulcers		
5. Have you ever taken blood-thinners?			10.TB or Lung disease		
			11. Hepatitis B or C / Liver Problems		
Females Only –Are you: (three questions)			12. Cancer or Tumors		
1. Pregnant?			13. Epilepsy or seizures		
2. Taking birth control pills?			14. Arthritis / rheumatism		
3. Currently nursing?			15. HIV or AIDS		
			16. Kidney problems / Dialysis		
			17. Osteoporosis		

Do you have any disease, condition, or problem not listed? No ❑ Yes ❑ (If yes, specify) __________________________

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I have answered the above questions truthfully and to the best of my knowledge. I am indicating my consent for routine diagnostic tests and procedures such as x-rays, cleaning, fillings, local anesthesia, blood pressure, glucose and HIV screening by signing below.

Patient/Parent/Legal Guardian	*(Signature)*	*(Date)*
Dental Provider	*(Signature)*	*(Date)*

Notes: (for dental staff use) ____

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____updated 1/30/2013