**DENTAL PATIENT MEDICAL HISTORY**

**Santa Ynez Tribal Health Clinic**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Please answer all of the following questions. If you are unsure how to answer any question(s), please ask the front office staff for assistance.** | | | | | | | | | | | | | | | | Chart #: | | |  | | | |
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| Patient Name: |  | | | | | | | | | | | | | DOB: |  | | | | | | | |
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| What is the name of your medical doctor? | | | | | |  | | | | | | | | | | | | | | | | |
| Please list medications you are taking? | | | | | |  | | | | | | | | | | | | | | | | |
| Are you allergic to any medications? | | | | | |  | | | | | | | | | | | | | | | | |
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| **PLEASE CHECK:** | | | | | | | | | | | **Y** | **N** |  | | | | | | | | | |
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| 1. Are you taking any blood thinners? | | | | | | | | | | |  |  |  | | | | | | | | | |
| 2. Are you taking any blood pressure medication? | | | | | | | | | | |  |  |  | | | | | | | | | |
| 3. Are you taking any heart medication? | | | | | | | | | | |  |  |  | | | | | | | | | |
| 4. Are you taking any calcium replacements? | | | | | | | | | | |  |  |  | | | | | | | | | |
| 5. Are you taking any other kind of medication? | | | | | | | | | | |  |  |  | | | | | | | | | |
| 6. Are you allergic to latex? | | | | | | | | | | |  |  |  | | | | | | | | | |
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| ***Do you currently have, or have you ever had, any of the following?*** | | | | | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **PLEASE CHECK:** | **Y** | **N** |  | **PLEASE CHECK:** | **Y** | **N** | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Heart attack | | | | | |  |  | |  | 16. Hepatitis | | | | | | | | | |  | |  |
| 2. Heart murmur | | | | | |  |  | |  | 17. HIV/Aids | | | | | | | | | |  | |  |
| 3. Heart valve/pace maker | | | | | |  |  | |  | 18. STD’s | | | | | | | | | |  | |  |
| 4. Heart stent | | | | | |  |  | |  | 19. Liver problems | | | | | | | | | |  | |  |
| 5. Any heart condition | | | | | |  |  | |  | 20. Kidney problems | | | | | | | | | |  | |  |
| 6. Artificial joint/replacement | | | | | |  |  | |  | 21. Asthma | | | | | | | | | |  | |  |
| 7. Stroke | | | | | |  |  | |  | 22. Sinus problem | | | | | | | | | |  | |  |
| 8. High blood pressure | | | | | |  |  | |  | 23. Nervous/Mental Disorder | | | | | | | | | |  | |  |
| 9. Rheumatic fever | | | | | |  |  | |  | 24. Anemia | | | | | | | | | |  | |  |
| 10. Epilepsy/seizures | | | | | |  |  | |  | 25. Ulcers | | | | | | | | | |  | |  |
| 11. Blood transfusion | | | | | |  |  | |  | 26. TB Lung Disease | | | | | | | | | |  | |  |
| 12. Cancer/Tumors | | | | | |  |  | |  | 27. Use Drugs | | | | | | | | | |  | |  |
| 13. Reaction to anesthesia | | | | | |  |  | |  | 28. Use Alcohol | | | | | | | | | |  | |  |
| 14. Bleeding disorders | | | | | |  |  | |  | 29. Use Tobacco | | | | | | | | | |  | |  |
| 15. Diabetes | | | | | |  |  | |  | If so, want to quit? | | | | | | | | | |  | |  |
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| **FEMALE PATIENTS ONLY:** | | | **ALL PATIENTS:** | | | | | | | | | | | | | | | | | | | |
| Are you currently: | | Y | N | | Do you have any other conditions, problems no listed? | | | | | | | | | | | | | | |  | |  |
| 1. Are you pregnant? | |  |  | | If yes, please specify: | | | | | | | |  | | | | | | | | | |
| 2. Taking birth control pills? | |  |  | | Do you have any concerns about receiving dental treatment? | | | | | | | | | | | | | | |  |  | |
| 3. Nursing? | |  |  | | If yes, please specify: | | | | | | | |  | | | | | | | | | |
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| *STAFF USE ONLY* | | | | **The answers I have given are true to the best of my knowledge. I am indicating my consent for routine dental procedures such as x-rays, cleaning, fillings, crowns, and local anesthesia by signing below.** | | | | | | | | | | | | | | | | | | |
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| Place stamp here | | | |
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|  | | | | **SIGNATURES** | | | | | | | | | | | | | | | | | | |
|  | | | | Patient: | | | |  | | | | | | | | Date: |  | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | | | |
|  | | | | Provider: | | | |  | | | | | | | | Date: | |  | | | | |