**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 #: |       |
|  |
| Patient Name: |  | DOB: |  |
|  |
| What is the name of your medical doctor? |       |
| Please list medications you are taking? |       |
| Are you allergic to any medications? |       |
|  |
| **PLEASE CHECK:** | **Y** | **N** |  |
|  |  |  |  |
| 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? | [ ]  | [ ]  |  |
|  |
| ***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?  | [ ]  | [ ]  |
|  |
| **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: |       |
|  |
| *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 |
|  |
|  |  |
|  | **SIGNATURES** |
|  | Patient: |       | Date: |       |
|  |  |
|  | Provider: |       | Date: |       |