San Diego American Indian
HEALTH CENTER

DENTAL PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

What is the reason for your dental visit today? _____
Do you have a toothache or dental pain now?.....Yes ☐ No ☐
Do you have any concerns about receiving dental treatment? If YES, please explain: _____
What is the name of your medical doctor and date of your last physical exam? _____
Has there been any change in your general health this past year?..... Yes ☐ No ☐
Do you take corticosteroids (e.g. Prednisone)?..... Yes ☐ No ☐
Do you have an allergy to Latex?..... Yes ☐ No ☐
Do you have any allergies to medication or other substances? (i.e. penicillin, sulfa, aspirin, codeine)……..Yes ☐ No ☐
If yes, please list: _____
List any medications (pills, drugs, herbal supplements) you are currently taking: _____
_____
_____

Have you EVER had the following: Please circle YES or NO (Do not write in gray columns)

Congenital Heart Defect/Murmur	Y	N		Infective Endocarditis	Y	N	
Heart Attack	Y	N		Human Papillomavirus (HPV)	Y	N	
Artificial Heart Valve or Pacemaker	Y	N		Herpes	Y	N	
High Blood Pressure	Y	N		HIV/AIDS	Y	N	
Stroke/Paralysis	Y	N		Hepatitis A, B, C or D	Y	N	
Asthma	Y	N		Arthritis/Rheumatism	Y	N	
Tuberculosis or Lung Disease	Y	N		Artificial Joint	Y	N	
Kidney Problems	Y	N		Osteoporosis/Bisphosphonate Usage	Y	N	
Liver Problems	Y	N		Cancer or Tumors	Y	N	
Stomach/Intestinal Disease/Ulcers	Y	N		Persistent Diarrhea	Y	N	
Epilepsy or Seizures	Y	N		Nervous or Mental Disorders	Y	N	
Diabetes	Y	N					
Thyroid Disorders	Y	N		FEMALES ONLY:			
Bleeding/Blood Disorder	Y	N		Are you pregnant?	Y	N	
Anemia	Y	N		Taking oral birth control pills?	Y	N	
Immune System Disorder	Y	N		Currently nursing?	Y	N	

1. Do you have any disease, condition or problem not listed? If YES, explain:	Y	N	6. HAVE YOU EVER DONE THE FOLLOWING?		
			Use Alcohol? If YES, please write how much and for how long:	Y	N
2. Have you had any recent hospitalizations or surgery?	Y	N	Use Drugs? (including marijuana) If YES, please write which kind, how much and how long:	Y	N
3. Have you ever had a bleeding problem that needed medical treatment? (e.g. Hemophilia)	Y	N			
4. Do you have chest pains currently?	Y	N			
5. Do you have a reason to believe you have been exposed to HIV or AIDS? If you have HIV or AIDS, what is your most recent: CD4 Count: _____ Viral Load: _____ Date of last lab work: _____	Y	N	Use Tobacco Products? (including e-cigarettes and cigars) If YES, please write how much and for how long:	Y	N

_____ Review by: _____
Signature Date