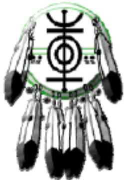

SMHWC Dental Patient Medical/Dental Health History Form

Name:________________________________ DOB:_________ City: ___________ Tribe:_____________ Phone: ______________

If you are a non-native, are you a Stockbridge Munsee Tribal employee or are you married to a Stockbridge Munsee Tribal member? Yes____ No____

Do you carry dental insurance? Yes____ No____

What is the name of your medical doctor? ____

Has there been any change in your general health this past year? ________________________________

If yes, please describe the changes: ____

List any medications (pills or drugs) that you have taken in the last two months: ______________________

____

____

List any known drug allergies you have: ____

Dental Information

For the following questions, mark (X) Yes, No, or Don't Know (DK).

Question	Yes	No	DK
Do your gums bleed when you brush or floss?	❑	❑	❑
Are your teeth sensitive to cold, hot, sweets, or pressure?	❑	❑	❑
Does food or floss catch between your teeth?	❑	❑	❑
Is your mouth dry?	❑	❑	❑
Have you had any periodontal (gum) treatments?	❑	❑	❑
Have you ever had orthodontics?	❑	❑	❑
Have you had any problems associated with previous dental treatment?	❑	❑	❑
Is your home water supply fluoridated?	❑	❑	❑
Do you drink bottled or filtered water?	❑	❑	❑
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY			
Are you currently experiencing dental pain or discomfort?	❑	❑	❑

Question	Yes	No	DK
Do you have earaches or neck pains?	❑	❑	❑
Do you have any clicking, popping or discomfort in the jaw?	❑	❑	❑
Do you clench or grind your teeth?	❑	❑	❑
Do you have sores or ulcers in your mouth?	❑	❑	❑
Do you wear dentures or partials?	❑	❑	❑
Do you participate in active recreational activities?	❑	❑	❑
Have you ever had a serious injury to your head or mouth?	❑	❑	❑
Have you been advised to take antibiotics prior to dental treatment for any reason?	❑	❑	❑

Date of your last dental exam: ________________

What was done at that time:

____

Date of last dental x-rays:____________________

What is the reason for your dental visit today?

How do you feel about your smile?

*There is a backside to this form

Medical Information

For the following questions, mark (X) Yes, No, or Don't Know (DK).

Question	Yes	No	DK
Have you had any serious illness or operation?	❑	❑	❑
If so, what was the illness or operations? ________ ____			
Do you have, or have you had any of the following diseases or problems?			
Damaged heart valves or artificial heart valves, including murmur	❑	❑	❑
Congenital heart disease	❑	❑	❑
Cardiovascular disease, heart trouble, heart attack, coronary insufficiency	❑	❑	❑
Coronary occlusion, high blood pressure, arteriosclerosis, stress	❑	❑	❑
Do you have a cardiac pacemaker?	❑	❑	❑
Do you ever have chest pains?	❑	❑	❑
Sinus troubles	❑	❑	❑
Asthma or hay fever	❑	❑	❑
COPD	❑	❑	❑
Hives or skin rash	❑	❑	❑
Fainting spells, seizures, or epilepsy	❑	❑	❑
Diabetes	❑	❑	❑
Do you have to urinate more than six times a day?	❑	❑	❑
Are you often thirsty?	❑	❑	❑
Does your mouth frequently become dry?	❑	❑	❑
Hepatitis, jaundice or liver disease	❑	❑	❑
Arthritis or inflammatory rheumatism (painful swollen joints)	❑	❑	❑
Artificial Joint	❑	❑	❑
Osteoporosis	❑	❑	❑
Stomach ulcers	❑	❑	❑
Kidney trouble/Dialysis	❑	❑	❑
Tuberculosis	❑	❑	❑
Do you have a persistent cough, or cough up blood?	❑	❑	❑
Low blood pressure	❑	❑	❑
Sexually Transmitted Diseases	❑	❑	❑
Psychiatric problems	❑	❑	❑
Anxiety	❑	❑	❑

Question	Yes	No	DK
Stroke	❑	❑	❑
Cancer or Leukemia	❑	❑	❑
AIDS or other immunosuppressive disorders	❑	❑	❑
Hepatitis Exposure	❑	❑	❑
Have you had abnormal bleeding associated with previous extractions, surgery, or trauma?	❑	❑	❑
Do you bruise easily?	❑	❑	❑
Have you ever required a blood transfusion?	❑	❑	❑
If so, explain the circumstances:________________			
Do you have any blood disorders, such as anemia, sickle cell disease?	❑	❑	❑
Do you consume alcohol or smoke cigarettes or smokeless tobacco on daily basis?	❑	❑	❑
Have you ever used drugs, cocaine, marijuana, prescription drugs..etc. for recreation?	❑	❑	❑
Have you had surgery, x-ray or drug treatment for a tumor, growth, or other conditions of your head or neck?	❑	❑	❑
Are you taking or have you taken either of the medications alendronate (Fosamax) or risedronate(Actonel) for osteoporosis or Paget's disease?	❑	❑	❑
Have you ever taken prescription diet pills?	❑	❑	❑
Since 2001 were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates(Aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	❑	❑	❑
Women			
Are you pregnant?	❑	❑	❑
Are you taking birth control?	❑	❑	❑
Are you currently nursing?	❑	❑	❑
Do you have any disease or illness not listed?			
If yes, list here: ______________________________ ____			

IMPORTANT

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 and local anesthesia by signing below.

Patient, parent or Guardian Signature ____ Date ___________

Provider Signature ____ Date ___________