ONEIDA

DENTAL HEALTH QUESTIONNAIRE for MR:_____

Name:_____ Birth Date:_____ Tribal Affiliation: _____

1) Who is your primary care dentist? _____

2) List all illnesses or surgeries: _____

3) List all medications: _____

4) Are you allergic to any medications? NO YES Names: _____

5) Do you have osteoporosis or have you taken Fosamax, Aredia or Zometa? NO YES

6) Is there any pain or discomfort in your mouth today? NO YES / Where: Top or Bottom / Right or Left Side

7) Circle any of the following which you have or have had:

Alcoholism	Developmental Disability	Liver Disease
Anemia	Diabetes	Low Blood Pressure
Anxiety Disorder	Drug Addiction	Metal Allergy
Arthritis	Epilepsy/Seizures	Rheumatic Fever
Asthma	Fainting/Dizzy Spells	Sinus Problems
Autism	Heart Murmur	STD's
Bi-Polar Disorder	Heart Stent	Stomach Problems
Bleeding Disorder	Heart Trouble	Stroke
Cancer Treatment	Hepatitis	Swollen Lymph Glands
Cardiac Pacemaker	High Blood Pressure	Thyroid Troubles
Chronic Cough	HIV/AIDS	Tobacco Use
Congenital Heart Lesion	Joint Replacement	Tuberculosis
Depression	Kidney Disease	Unintentional Weight Loss

8) What additional information should we know about your health?_____

_____

9) If you are female could you be or are you pregnant? NO YES Due Date: _____

10) Circle any of the following which you have had in the past:

Braces	Dry Mouth	Jaw/Joint Problems
Bleeding Gums	Gum Surgery	Pain in Chewing
Clenching/Grinding	Hot/Cold Sensitivity	Root Canal Treatment
Cold/Canker Sores		

I _____ the parent / guardian of _____
consent to have all medication / dental services necessary performed on my child by the attending dentist.

_____ _____

Signature of Patient or Guardian ***Date***