Oneida Comprehensive Health Division
Oneida Community Health Center
Behavioral Health Services
Anna John Resident Centered Care Community
Employee Health Nursing

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? ☐YES ☐NO Names: _____
5) Do you have osteoporosis, or have you taken Fosamax, Aredia or Zometa? ☐YES ☐NO
6) Is there any pain or discomfort in your mouth today? ☐YES ☐NO Where: ☐ Left side ☐ Right side
   ☐ Upper ☐ Lower
7) Select 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 Problem
☐ 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? ☐YES ☐NO Due Date: _____
10) Select any of the following which you have had in the past:

☐ Braces	☐ Dry Mouth	☐ Jaw Joint
☐ 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***

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