Dental Health History

ANCHORAGE NEIGHBORHOOD HEALTH CENTER

General Information	
Name (first, middle, last)	Date of birth
Reason for your dental visit	Do you have dental pain now?
	☐ Yes ☐ No
Previous dental provider	Date of your last dental exam
Current medical provider	Date of your last medical exam

Health History

Are you currently experiencing, or have you recently experienced any of the following symptoms?

- ☐ Bleeding problems, bruising easily
- ☐ Blurred vision
- ☐ Diarrhea, constipation, blood in stool
- ☐ Difficulty swallowing
- ☐ Dry mouth
- ☐ Excessive thirst
- ☐ Fainting spells, dizziness
- ☐ Frequent or difficult urination, blood in urine
- ☐ Frequent vomiting, nausea
- ☐ Headaches
- ☐ Jaundice
- ☐ Persistent cough, coughing up blood
- ☐ Ringing in ears
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Swollen ankles
- ☐ Weight loss/fever/night sweats
- ☐ Other:

Have you ever had any of the following conditions or procedures?

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial joint
- ☐ Cancer, tumors
- ☐ Chemotherapy
- ☐ Asthma, TB, emphysema, lung disease
- ☐ Blood transfusion
- ☐ Chest pain or angina
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Heart defects, heart murmurs
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Liver disease (besides hepatitis)
- ☐ High blood pressure
- ☐ Kidney or bladder disease
- ☐ Pacemaker
- ☐ Prosthetic heart valve
- ☐ Radiation treatment
- ☐ Rheumatic fever
- ☐ Rheumatoid arthritis
- ☐ STD
- ☐ Seizures
- ☐ Skin disease
- ☐ Stroke
- ☐ Stomach problems, ulcers
- ☐ Thyroid or adrenal disease
- ☐ Other:

Additional Medical Questions			
Has your health changed in the past one (1) year? ***If yes, please describe:***			☐ Yes ☐ No
Have you had a serious illness or hospitalization in the past three (3) years? ***If yes, please describe:***			☐ Yes ☐ No
Are you usings any of the following?	☐ Recreational drugs ☐ Other	☐ Tobacco ☐ None	☐ Alcohol
Are you currently being treated by a behavioral health provider for conditions like depression, anxiety, PTSD, substance use disorder, etc.?			☐ Yes ☐ No
Have you ever had a problem with a dental treatment? ***If yes, please describe:***			☐ Yes ☐ No
Have you taken blood thinners in the past thirty (30) days, such as aspirin, warfarin, Pradaxa, Xarelto, Eliquis, etc.? ***If yes, which?***			☐ Yes ☐ No
Have you taken bisphosphonates in the past five (5) years, such as Fosamax, Actonel, Boniva, Didronel, Reclast, Zometa, etc.? ***If yes, which?***			☐ Yes ☐ No
Please check if you are currently:	☐ Pregnant	☐ Nursing	☐ Taking birth control

Current Medications (including inhalors, herbs, supplements, and over-the-counter medications)

Medication	Dose	Start date

Medication Allergies

Medication	Reaction	Severity

Signatures

I have answered each question completely and accurately. I will tell my dentist if my health and/or medications change.

Patient signature	Date
Dentist signature	**Date**