SNAHC
Sacramento Native American Health Center
a californiahealth+ center

DENTAL CENTER

_____
Patient Name

_____
Date of Birth

_____
HRN

Gender Identity ☐ **M** ☐ **Transgender M**
☐ **F** ☐ **Transgender F**

Dental Health History

Note: This information is confidential and will be reviewed by the provider. The information will be used to update your medical record.

General Health - Check YES or NO.

Yes No

☐ ☐ Is your general health good? If NO, explain _____

☐ ☐ Has there been a change in your health within the last year? If YES, explain.

_____

☐ ☐ Have you gone to the hospital or emergency room or had a serious illness in the last three years? If YES, explain _____

☐ ☐ Do you have a medical provider now?

Provider _____ Date of last medical exam _____

☐ ☐ Have you had problems with prior dental treatment?

☐ ☐ Are you in pain now? Date of last dental exam _____

Date of last cleaning/hygiene appointment _____Date of last dental x-rays _____

☐ ☐ Do you need assistance getting up from a chair?

Circle all foods you eat on a typical day: Fat Fiber Caffeine Salt Sugar Water/Fluid

MEDICATIONS - Please list all medications you take and their dosages, either prescription or over the counter.

☐ **None**

Medication	Dose	Medication	Dose
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES – Are you allergic to or have you had a reaction to any of the following? Check each that apply.

☐ Food (such as shellfish, nuts, etc.) If yes, what? _____

☐ Medications (such as antibiotics or pain medicine) If yes, which? _____

☐ Latex ☐ Metals ☐ Animals

☐ Local anesthetic or nitrous oxide

☐ Other allergies you need to tell us about? If so, what? _____

Name _____ DOB _____ HRN _____

HAVE YOU EXPERIENCED:

Yes	No	
☐	☐	Chest pain/tightness
☐	☐	Swollen ankles
☐	☐	Shortness of breath
☐	☐	Recent weight loss, fever, night sweats
☐	☐	Persistent cough, coughing up blood
☐	☐	Bleeding problems, bruising easily

Yes	No	
☐	☐	Sinus problems
☐	☐	Difficulty swallowing
☐	☐	Diarrhea, constipation, blood in stools
☐	☐	Frequent vomiting, nausea
☐	☐	Difficulty urinating, blood in urine
☐	☐	Dizziness
☐	☐	Ringing in ears
☐	☐	Fainting spells

Yes	No	
☐	☐	Headaches
☐	☐	Blurred vision
☐	☐	Seizures
☐	☐	Excessive thirst
☐	☐	Frequent urination
☐	☐	Dry mouth
☐	☐	Jaundice
☐	☐	Joint pain, stiffness

DO YOU HAVE OR HAVE YOU HAD:

Yes	No	
☐	☐	Heart disease
☐	☐	Heart attack, heart defects
☐	☐	History of Heart Murmur
☐	☐	Rheumatic fever
☐	☐	Stroke, hardening of arteries
☐	☐	High blood pressure
☐	☐	Asthma, TB, emphysema, other lung disease
☐	☐	Stomach problems, ulcers
☐	☐	Psychiatric care
☐	☐	Radiation treatment

Yes	No	
☐	☐	Chemotherapy
☐	☐	Prosthetic heart valve
☐	☐	Hepatitis, other liver disease
☐	☐	Family history of diabetes, heart problems, tumors
☐	☐	AIDS/HIV
☐	☐	Sexually transmitted infection (herpes, syphilis, gonorrhea)
☐	☐	Artificial joint
☐	☐	Hospitalization

Yes	No	
☐	☐	Blood transfusion
☐	☐	Surgeries
☐	☐	Tumors, cancer
☐	☐	Arthritis, rheumatism
☐	☐	Eye diseases
☐	☐	Skin diseases
☐	☐	Anemia/blood problems
☐	☐	Kidney, bladder disease
☐	☐	Thyroid, adrenal disease
☐	☐	Diabetes
☐	☐	Pacemaker
☐	☐	Contact lenses

Do you have or have you had any other disease or medical problem not listed on this form? If so, please explain:

_____

WOMEN ONLY:

Yes	No		Yes	No	
☐	☐	Are you or could you be pregnant or nursing?	☐	☐	Are you currently taking birth control pills?

ARE YOU TAKING:

Yes	No		Yes	No	
☐	☐	Recreational drugs	☐	☐	Tobacco in any form
☐	☐	More than 2 alcohol drinks/day			

The above information is true and accurate to the best of my recollection.

Patient Signature: _____ **Date: _____**

Provider Name: _____Signature: _____ Review Date:_____