Sunshine Community Health Center

HC 89 Box 8190, Mile 4.4 Talkeetna Spur Rd, Talkeetna, AK 99676
Willow Clinic: PO Box 1049, 24091 Long Lake Road, Willow, AK 99688
Telephone: 907-733-2273 Fax: 907-733-1735 E-Mail: SCHC@sunshineclinic.org

Patient Name:_____Date of Birth:_____Today's Date:_____

Do you like your smile? ☐YES ☐No: Please Explain_____
Are you currently taking any blood thinners? ☐ Yes Type:_____ ☐ No
Do you have an allergies to medications? ☐YES ☐No

Drug Type	Reaction

Health History: Do you have or have you ever had problems with the following: (Please circle)

- Frequent/Severe Headaches Migraines
- Fainting Spells
- Seizures/Epilepsy
- Stroke
- Head Injury
- Vision Problems
- Glaucoma
- Hearing Loss
- Sinus Problems
- Thyroid
- Breast Problems
- Chest Pain
- Palpitation or Heart Pounding Heart Attack
- Heart Disease
- High Blood Pressure
- Heart Murmur
- Rheumatic Fever
- Artificial Heart Valves
- Heart Valve Problems
- Heart Surgery
- Shortness of Breath
- Chronic Cough
- Asthma Emphysema
- Tuberculosis
- Coughing up Blood
- Heartburn
- Stomach Problems
- Hernias
- Gallbladder
- Diabetes
- High Cholesterol
- Liver Disease
- Hepatitis
- Frequent or Painful Urination
- Kidney Stone/Blood Urine
- Sexually Transmitted Disease
- HIV Positive
- Immune Problem
- Swollen or Painful Joints
- Chronic Back Pain
- Gout
- Arthritis/Rheumatism/Bursitis
- Osteoporosis
- Joint Replacement
- Nerve Injury
- Blood Clots
- Anemia
- Blood Disorder
- Blood Transfusion
- Cancer:_____
- Exposure to Toxins
- Skin Problems
- Self-Confidence Concerns
- Eating Disorder
- Depression
- Anxiety
- Suicide Attempt or Plan
- Domestic Violence
- Sexual Abuse

Please answer the following questions:

☐Yes ☐No Are you currently in dental pain?

☐Yes ☐No Have you had complications with prior dental treatment?

☐Yes ☐No Have you ever had any joint replacement? If yes please explain:_____

☐Yes ☐No Have you ever been told you needed to take a pre-med before dental treatment?

☐Yes ☐No Have you ever had an adverse reaction to local anesthetic? If yes please explain:_____

☐Yes ☐No Have you had any surgeries /hospitalizations in the past 10 years? If yes please explain:_____

☐Yes ☐No Have you had any periodontal (gum) treatment?

☐Yes ☐No Do you wear any removable dental appliances (complete or partial dentures)?

Women Only: Are you currently pregnant or nursing? ☐Yes ☐No