

DENTAL/MEDICAL HISTORY FORM

PATIENT NAME: _____

DATE OF BIRTH: _____

DENTAL INFORMATION: Reason for today's visit (circle one): EXAM/EVALUATION, TREATMENT, EMERGENCY

Are you in pain? _____ How Long? _____ Where? _____

Please indicate any of the following problems you are experiencing currently or have had in the past:

Lost/Broken Filling(s) Broken/Chipped Tooth Red/Swollen/Bleeding Gums Sensitive Teeth/Gums

Bad Breath Blisters/Sores in or around mouth Stained Teeth TMJ/Jaw Problems Other: _____

Do you require Pre-Medication prior to dental procedures?(Y/N) If yes, Why? _____

Prior Dentist: _____ Phone Number: _____ Last Exam/Xrays: _____

Have your past experiences in a dental office always been positive? _____

How many times a day do you brush? _____ How many times a week do you floss? _____

How would you rate your smile? (WORST) 1 2 3 4 5 6 7 8 9 10 (BEST) Are you interested in teeth whitening? (Y/N)

MEDICAL HISTORY: Please read and answer each question carefully!

Are you currently under a physician's care?(Y/N) Why? _____ Dr Name: _____ Ph # _____

When was the date of your last physical exam? _____

Have you ever been hospitalized or had any major surgeries? (Y/N) When/Why _____

Are you currently taking prescription and/or over the counter medication(Y/N) What? _____

Are you allergic to any medications/substances? Including but not limited to:

Aspirin Penicillin/Amoxicillin Codeine Metal Latex/Rubber Other: _____

Do you have or have had any of the following diseases, medical conditions or procedures?

Y/N...Heart Attack/Stroke If yes, What year:

Y/N...Irregular Heartbeat/Pacemaker

Y/N...Heart murmur...w/Regurgitation(Y/N)

Y/N...Rheumatic Fever...w/Heart Valve Damage

Y/N...Mitral Valve Prolapse

Y/N...Artificial Heart Valves

Y/N...Heart Disease

Y/N...History of Infective Endocarditis

Y/N...Congenital Heart Defect

Y/N...Chest Pains

Y/N...High/Low Blood Pressure

Y/N...Kidney Problems

Y/N...Thyroid Problems

Y/N...Kidney Problems

Y/N...Liver Problems

Y/N...Respiratory Problems

Y/N...Sinus Problems

Y/N...Asthma...do you carry Albuterol(Y/N)

Y/N...Stomach Problems/Ulcers

Y/N...Nervousness

Y/N...Prosthetic/Joint Replacements If yes, What Year:

Y/N...Anemia

Y/N...Jaw Problems/TMD

Y/N...Alcohol/Drug Abuse

Y/N...Tuberculosis(TB)

Y/N...Cancer/Tumors

Y/N...Chemotherapy

Y/N...Radiation Treatment

Y/N...Shingles

Y/N...HIV+/AIDS

Y/N...Arthritis/Rheumatism

Y/N...Fainting/Seizures/Epilepsy

Y/N...Severe/Frequent Headaches

Y/N...Back/Neck Pain

Y/N...Diabetes/Hypoglycemia

Y/N...Leukimia

Y/N...Glaucoma

Y/N...Emphysema

Y/N...Difficulty Breathing

Y/N...Psychiatric Problems

Y/N...Venereal Disease

WOMEN(Please Circle): Pregnant/Trying to conceive Nursing Taking Oral Contraceptives: _____

Are you aware that taking antibiotics will negate the effects of oral contraceptives? (Y/N)

Are you currently taking any Biphosphonates for osteoporosis? (Y/N)

Authorization:

I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE AND I ALSO UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE INFORMATION I HAVE PROVIDED

Patient/Parent/Guardian Signature

Date

Doctor Signature

Date

KEVIN CHANG DDS, INC.