MEDICAL HISTORY

Patient's Name _____

Physician's Name _____ Phone _____

Address _____

1.	Are you under the care of your physician? If yes, for what?_____	Yes	No
2.	Have you been hospitalized or had surgical operation or serious illness within the past five years?	Yes	No
3.	Are you taking any medication, drugs or controlled substances, including regular dosage of aspirin? If yes, please list name and dosage: _____	Yes	No
4.	Have you ever taken prescription medication for weight loss (diet pills)? (i.e. Fen-Phen, Redux, etc.)	Yes	No
5.	Do you smoke or chew tobacco?	Yes	No
6.	Are you wearing contact lenses?	Yes	No
7.	Have you lost or gained more than 10 pounds in the past year?	Yes	No
8.	<Women> Are you: Pregnant? Yes, ____ Months/ No Nursing? Yes/ No Taking birth control pills? Yes/ No		
9.	Are you aware of having an allergic (or adverse) reaction to any medication or substance? If yes, please list: _____	Yes	No

10. Circle and Indicate which of the following you have had, or have at present.

Heart (Surgery, Disease, Attack)	Ulcers	Cold Sores / Fever Blisters
Heart Pacemaker	Diabetes	Blood Transfusion
Chest Pain	Thyroid Problems	Hemophilia
Congenital Heart Disease	Anemia	Liver Disease
Heart Murmur	Chronic Cough	Yellow Jaundice
High / Low Blood Pressure	Tuberculosis	Mitral Valve Prolapse
Rheumatic Fever	Hay Fever	Sickle Cell Disease
Arthritis / Rheumatism	Latex Sensitivity	Bruise Easily
Swollen Ankles	Allergies or Hives	Neurological Disorders
Epilepsy or Seizures	Sinus Trouble	Psychiatric / Psychological Care
Fainting or Dizzy Spells	Radiation Therapy	Sexually Transmitted Disease
Asthma	Chemotherapy	Glaucoma
Leukemia	Tumors	Emphysema
Stroke	Hepatitis A B C (circle)	Angina
Diet (Special/Restricted)	Venereal Disease	Cortisone Medicine
Artificial Joints (hip, knee, etc)	A.I.D.S	Artificial Heart Valve
Kidney Diseases	H.I.V. Positive	Lung Problems

11.	Do you have or have you had any disease, condition, or problem not listed? If yes, please list: _____	Yes	No

DENTAL HISTORY

Last Dental Visit and Reason _____

Previous Dentist's Name _____ Phone _____

Address _____

1.	Do your gums bleed while brushing or flossing?	Yes	No
2.	Are your teeth sensitive to hot, cold, sweet or sour liquids or foods? If yes, please indicate what and where: _____	Yes	No
3.	Do you have a toothache? If yes, please indicate where: _____	Yes	No
4.	Have you ever had injuries to your head, neck or jaw?	Yes	No
5.	Do you have any jaw joint problems? (i.e. clicking, painful joints, difficulty in chewing, headaches)	Yes	No
6.	Do you have any oral habits? (i.e. biting your finger nails or lips, pencil ends, etc)	Yes	No
7.	Do you have a bleeding problem? (i.e. prolong bleeding following tooth extraction)	Yes	No
8.	Have you had braces or orthodontic treatment?	Yes	No
9.	Do you wear dentures, plates, or partials? If yes, date of placement: _____	Yes	No
10.	Have your dentist or hygienist teach you the correct methods of brushing and flossing?	Yes	No

11. I brush my teeth _____ times a day, and I floss _____ times a day.

I have answered the above questions to the best of my knowledge. I understand that inaccurate or omitted information can be dangerous to my health, and may cause adverse reaction and affect the outcome of my dental treatment. I will notify the doctor of change in my health or medication.

Patient/ Guardian Signature _____ **Date** _____

KA-WING CHEW, D.D.S.

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