## DENTAL HISTORY OF PATIENT

Patient Name: ______________________________ Nickname: ___________________ Date of Birth: _____________

Please indicate your preferred spoken language ________________________________

( We are required by law [ CA Health and Safety Code AB800, Section 123147 ] to request this information)

Emergency Visit: Yes ____ No ____ 1st Visit to a Dentist Yes ____ No ____ Male ____ Female ____

Name of Former Dentist: _________________________________________ City: _____________________________

Have any other family members been a patient of our office before? Yes ____ No ____

If yes, please provide their names: ___________________________________________________________________

Present dental problem as you see it (if any): ______________________________________________________________

Has the patient had any past bad experiences ? Yes ____ No ____

If yes, please explain: ____________________________________________________________________________

How did you hear of us? ❑ Television ❑ Newspaper ❑ Phonebook ❑ Internet ❑ Health Fair

❑ Other ________________________________________________________

Emergency Contact Name/Relationship: __________________________________ Phone: ________________________

## MEDICAL HISTORY

*The following answers are confidential and are for our records only.*
*Your accurate answers will assist us to render the best possible dental care. Thank you.*

Is the patient in good health? Yes ____ No ____ Explain: ______________________________________________

Has there been any change in the patient's general health within the past year? Yes ____ No ____

The last physical examination was on: ______________________________________________

Is the patient currently under the care of a physician? Yes ____ No ____

If yes, provide the condition being treated: ___________________________________________________________

Physician's Name: ________________________________________________ Phone: _______________________

Physician's Address: _____________________________________________________________________________

Is the patient currently taking any drugs or medication? Yes ____ No ____

If yes, please list: _______________________________________________________________________________

Has the patient been hospitalized or had a serious illness within the past 5 years? Yes ____ No ____

If yes, please explain: ____________________________________________________________________________

Has the patient had abnormal bleeding with previous extractions, surgery or trauma? Yes ____ No ____

If yes, please explain: ____________________________________________________________________________

Has the patient had surgery or x-ray treatment for a tumor, growth or other condition? Yes ____ No ____

If yes, please explain: ____________________________________________________________________________

## DOES THE PATIENT HAVE OR HAD ANY OF THE FOLLOWING?

| Condition | | | Condition | | | Condition | | |
|---|---|---|---|---|---|---|---|---|
| Rheumatic Fever | Yes | No | Diabetes | Yes | No | Short of Breath after Mild Exercise | Yes | No |
| Rheumatic Heart Disease | Yes | No | Arthritis | Yes | No | Hepatitis, Jaundice or Liver Disease | Yes | No |
| Congenital Heart Lesions | Yes | No | Stomach Ulcers | Yes | No | Blood Disorder such as Anemia | Yes | No |
| Cardiovascular Disease | Yes | No | Kidney Trouble | Yes | No | Other ______________________ | | |
| Heart Murmur | Yes | No | Tuberculosis | Yes | No | ______________________ | | |
| Allergies | Yes | No | Persistent Cough | Yes | No | ______________________ | | |
| Sinus Trouble | Yes | No | Coughing of Blood | Yes | No | ______________________ | | |
| Asthma or Hay Fever | Yes | No | Autoimmune Disease | Yes | No | | | |
| Hives or Skin Rash | Yes | No | Bruise Easily | Yes | No | | | |
| Fainting Spells or Seizures | Yes | No | Premature Birth | Yes | No | | | |

## IS THE PATIENT ROUTINELY TAKING ANY OF THE FOLLOWING MEDICATIONS?

| | | | | | | |
|---|---|---|---|---|---|---|
| Antibiotics or Sulfa Drugs | Yes | No | Ritalin | Yes | No | Other ______________ |
| Cortisone (Steroids) | Yes | No | Anticoagulants (Blood Thinners) | Yes | No | ______________ |
| Tranquilizers | Yes | No | Digoxin or Drugs for Heart Trouble | Yes | No | ______________ |
| Antihistamines | Yes | No | | | | ______________ |
| Aspirin | Yes | No | | | | ______________ |
| Insulin or Similar Drug | Yes | No | | | | |

## HISTORY OF ALLERGIC REACTION IN THE PATIENT OR IMMEDIATE FAMILY

| | | | | | | |
|---|---|---|---|---|---|---|
| Latex | Yes | No | Aspirin | Yes | No | Other ______________ |
| Local Anesthetics | Yes | No | Penicillin or Other Antibiotics | Yes | No | ______________ |
| Sulfa Drugs | Yes | No | Codeine or Other Narcotics | Yes | No | ______________ |
| Barbiturates | Yes | No | | | | ______________ |
| Sedatives | Yes | No | | | | ______________ |
| Sleeping Pills | Yes | No | | | | |

Do the patient use or has used bisphosphonate? Yes ____ No ____

Does the patient have any medical condition not listed above? Yes ____ No ____

If yes, please explain: ____________________________________________

Does the patient have any special needs? Yes ____ No ____

If yes, please explain: ____________________________________________

I hereby certify that I have read the foregoing and filled out this questionaire completely. I have advised you of all medical problems of which I am aware. I consent to have Drs. Chiang, Morris, Murillo, Saisho and their Associates and staff perform diagnostic dental procedures including x-rays, teeth cleaning, oral examination and application of fluoride on teeth. I understand that before any further care is rendered, I will be so informed and consent obtained.

______________________ ______________________ __________ __________

Signature of Parent / Legal Guardian | Printed Name of Parent / Legal Guardian | Date | Time

**FOR DENTISTS ONLY**

**Patient Resume:**

**Hospitalizations:**

**Surgeries:**

**Medications:**

**Allergies:**

**Medical Alert:**

**A.S.A. I, II, III, IV** ❑ **Medical Consults Requested**

______________________ __________ __________

Signature of Dentist | Date | Time