Medical History

Name _____ Age_____ Sex M / F General Health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of Physician(s) _____ Phone# (___)_____ Last Physical Exam _____

* Are you under treatment for any current condition? Yes / No If YES, what condition? _____

* Are you taking any medications? Yes / No If YES, Name & dosage _____

_____

* Are you taking or have taken Bisphosphonates (Fosamax, Actonel, Zometa Boniva, Didronel, or Aredia) for osteoporosis, chemotherapy for multiple myeloma, breast cancer, bone metastasis or Paget's disease? Yes / No

* Have you had or do you plan on having an H.I.V (AIDS) test? Yes / No If YES, Results _____ When ? _____

* Do/Did you use Tobacco? Yes / No If YES, ___ pcs a day or quit ___ months/ years ago

* Have you ever been treated for or been informed you have any of the followings; (including past history and current conditions)

1. Heart problems / murmur	Yes / No	16. Blood transfusion	Yes / No
2. Shortness of breathe	Yes / No	17. Diabetes	Yes / No
3. High blood pressure	Yes / No	18. Epilepsy / Seizures	Yes / No
4. Rheumatic fever	Yes / No	19. Thyroid problem	Yes / No
5. Artificial heart valve	Yes / No	20. Ulcer	Yes / No
6. Pacemaker	Yes / No	21. Arthritis	Yes / No
7. Lung problem /TB	Yes / No	22. Glaucoma	Yes / No
8. Respiratory disease	Yes / No	23. Cancer	Yes / No
9. Asthma	Yes / No	24. Chemo-/Radiotherapy	Yes / No
10. Liver problem /Hepatitis Type ___	Yes / No	25. Psychiatric care	Yes / No
11. Kidney problem	Yes / No	26. Venereal disease	Yes / No
12. Swelling ankles	Yes / No	27. Taking birth control pills	Yes / No
13. Anemia	Yes / No	28. Pregnant (Women)	Yes / No Due date ____
14. Blood disease	Yes / No	29. Subject to fainting spell	Yes / No
15. Hemophilia	Yes / No	30. Allergy	Yes / No
		If YES, Penicillin/ Sulfa/ Codeine/ Local Anesthetics/ Others	

Dental History

Reason for Today's visit: _____ Last dental visit: _____(Country)_____

1. Pain when eating cold / hot / sweet	Yes / No	10. Difficulty opening or closing mouth	Yes / No
2. Loose filling / lost filling / food impaction	Yes / No	11. Pain in the ear area	Yes / No
3. Gum bleeding when brushing / flossing	Yes / No	12. Headache with shoulder / neck tenderness	Yes / No
4. Bad breath / unpleasant taste	Yes / No	13. **Concern(s) for dental/ oral care?**	
5. Sore/ swelling/ lumping in the mouth	Yes / No	☐ Front teeth: Don't like the Color/ Alignment/ Want to look natural	
6. Burning tongue or lips	Yes / No		
7. Clenching or grinding teeth	Yes / No	☐ Back teeth: Difficult to chew	
8. Every 6 months dental care (past 2 years)	Yes / No	☐ Others _____	
9. Use dental floss (past 2 years)	Yes / No		
If YES, ___ times a day/ week/ month (circle one)			

Signature: _____ Date: _____

(Parent or legal guardian if patient is minor, power of attorney must be represented, if necessary.)