

## Health History Form

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

Your answers are confidential and will be used strictly for our records. Please note that during your initial visit you will be asked questions about your responses on this questionnaire. In order to receive treatment this form must be filled out completely.

### DENTAL HISTORY

YES NO

Do you have a specific dental problem? \_\_\_\_\_  YES  NO

Do you like your smile? Why or why not? \_\_\_\_\_  YES  NO

Do you want to keep your remaining teeth? \_\_\_\_\_  YES  NO

Has fear of discomfort kept you from regular visits? \_\_\_\_\_  YES  NO

Do your gums ever bleed? \_\_\_\_\_  YES  NO

Have you ever had any of the following (please check all that apply):

Injury to face, jaw or teeth     Oral Surgery     Orthodontic Treatment     Periodontal (gum) Surgery

Do you ever experience the following symptoms (please check all that apply):

Headaches     TMJ Pain     Ear Congestion     Tender, Sensitive Teeth  
 Vertigo (dizziness)     TMJ Noise     Tinnitus (ringing in ears)     Thermal Sensitivity (Hot or Cold)  
 Cervical Pain     Clenching/Bruxing     Tingling in Fingertips     Nervousness/Insomnia

### MEDICAL HISTORY

YES NO

Are you in good health? \_\_\_\_\_  YES  NO

Have there been any changes to your general health within the past year? \_\_\_\_\_  YES  NO

Are you under a physician's care now? Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone \_\_\_\_\_  YES  NO

Have you ever been hospitalized or had a major operation? \_\_\_\_\_  YES  NO

Are you taking any medication, pills or drugs? What? \_\_\_\_\_  YES  NO

Are you taking or have you taken any diet drugs such as Pondimin (fenduramine), Redux (dexphenfluramine) or Phen-fen (phentermine)?  YES  NO

Are you taking any bis-phosphonates to treat osteoporosis? If so, which one? \_\_\_\_\_  YES  NO

Are you allergic to, or had a reaction to, any medications or substances? Please check box below:

Aspirin     Penicillin     Codeine     Acrylic     Metal     Latex Rubber     Local Anesthetics     Other \_\_\_\_\_

*Women* (Please Check):     Pregnant or Trying to get pregnant     Nursing     Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check all that apply:

Heart Trouble/Disease     Congenital Heart Disorder     Stroke     Cancer  
 Heart Murmur     Damaged Heart Valves     Diabetes     Epilepsy/Neurological Disease  
 Irregular Heart Beat     Artificial Heart Valves     Hepatitis A B C (*circle one*)     Stomach Ulcer  
 Angina/Chest Pain     High Blood Pressure     AIDS or HIV Infection     Artificial Joints  
 Heart Attack/Failure     Low Blood Pressure     Venereal Disease     Abnormal Bleeding  
 Rheumatic Heart Disease     Kidney Problems     Tumor or Growth     Asthma

Have you had any other serious illness not checked above? \_\_\_\_\_ YES NO

To the best of my knowledge, all the preceding answers are correct. I will not hold Dr. Cheung, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X \_\_\_\_\_  
 PATIENT SIGNATURE (PARENT OR GUARDIAN)

Date \_\_\_\_\_

Reviewed by Doctor \_\_\_\_\_

Date \_\_\_\_\_

History Review and Significant Findings \_\_\_\_\_