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MEDICAL HEALTH HISTORY

Patient Name _____

Physician's Name _____ Date of Last Visit _____

Phone _____

Have you had any serious illnesses or operations: ☐ Yes ☐ No If yes, describe _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing ☐ Yes ☐ No Taking birth control pills ☐ Yes ☐ No

Do you have or have you had any of the following? Please check (✓) any that apply.

- ☐ Angina/Chest Pain
- ☐ Heart Surgery
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Heart Attack
- ☐ Scarlet Fever
- ☐ Rheumatic Fever
- ☐ Pace Maker
- ☐ Artificial Heart valve
- ☐ Bruise Easily
- ☐ Abnormal Bleeding/Hemophilia
- ☐ Anemia
- ☐ Blood Transfusion
  Date _____
- ☐ Hay Fever
- ☐ Sinus Problems
- ☐ Sleep Apnea
- ☐ Skin Rash
- ☐ Asthma
- ☐ Ulcer
- ☐ Gastric Esophageal Reflux Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Bladder Problems
- ☐ Hepatitis (A,B,C) _____
- ☐ Arthritis
- ☐ Back or Neck Pain
- ☐ Joint Replacement (Artificial Joints) _____
- ☐ Epilepsy/Seizures
- ☐ Stroke
- ☐ Frequent Headaches
- ☐ Migraine
- ☐ Thyroid Problems
- ☐ Antibiotic Premedication for Dental Treatment
- ☐ Anxiety Disorder
- ☐ Psychiatric Treatment
- ☐ Cancer/Tumor
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ Diabetes _____
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Chemical Dependency
- ☐ Alcoholism
- ☐ Herpes/Cold Sores
- ☐ Other STD _____
- ☐ HIV/AIDS
- ☐ Glaucoma
- ☐ Bulemia/Anorexia
- ☐ Cosmetic Surgery
- ☐ Tobacco Habit
  If yes, how much? _____

Do you have any condition or disease not listed above? ☐ Yes ☐ No

If so, Please describe _____

MEDICATIONS

List Medications you are currently taking including herbal medications _____

_____

_____

_____

_____

ALLERGIES

- ☐ Aspirin, Ibuprofen
- ☐ Barbituates, Sedatives or Sleeping Pills
- ☐ Codeine, Demerol or Other Narcotics
- ☐ Sulfa Drugs
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Erythromycin
- ☐ Other Antibiotics _____
- ☐ Latex, Rubber Dam
- ☐ Other _____ _____

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Kim or any members of her staff responsible for any errors or omissions that I may have made in the completion of this form. I will inform the doctor if my health or medications change in any way.

Signature _____ Date _____

DENTAL HEALTH HISTORY

Reason for today's visit _____

Former Dentist _____ Date of last dental visit _____

Address _____ Date of last dental x-rays _____

Please check (✓) if you have had any of the following:

- ☐ Past Orthodontic Treatment
- ☐ Periodontal Treatment/Surgery
- ☐ Cracking or Popping Jaw
- ☐ Jaw Joint Pain
- ☐ Nightguard/Dayguard
- ☐ Grinding or Clenching at Night
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Sweets
- ☐ Loose Teeth
- ☐ Bleeding Gums
- ☐ Bad Breath
- ☐ Sores or Ulcers in Your Mouth
- ☐ Food Collection Between Teeth
- ☐ Broken Fillings
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Biting Pressure

Would you describe your present dental health as good? Comments _____

_____

_____

Are you satisfied with your smile and the appearance of you teeth? _____

_____

How often do you floss? _____ How often do you brush? _____

Are you apprehensive about dental treatment? _____

Have you ever had a bad experience in a dental office? If so, please describe. _____

_____

_____

CONSENT

- I authorize Dr. Kim to take x-rays, study models, photographs and any other diagnostic aids appropriate to make a thorough diagnosis of my dental needs with my permission.
- I also understand the use of anesthetic agents embodies a certain risk.

Patient _____ Date _____

Parent or Guardian _____

Relationship to patient _____