C W. Chung DDS _Nathan C. Lee DDS

Medical History Form Version 1(Copy)

Patient Name: Birth Date: Date Created:

Please list all prescription and non-prescription medications, vitamins, and supplements.	◯ Yes ◯ No	If yes
Are you presently, or have you been under the care of a physician during the past year?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major	◯ Yes ◯ No	If yes
Are you allergic to any medicine or materials?	◯ Yes ◯ No	If yes

Are you allergic to any medicine or materials?

☐ Local Anesthetic	☐ Penicillin	☐ Codeine	☐ Sulfa drugs
☐ Aspirin	☐ Latex	☐ Acrylic / Metal	☐ Other Allergy

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonates?	◯ Yes ◯ No	If yes
Do you smoke or use any other tobacco products? If yes, how often do you use?	◯ Yes ◯ No	If yes
Have you even been required to take Antibiotic prior to dental visit?	◯ Yes ◯ No	If yes

Dental/Oral cavity/Head and Neck related conditions

☐ Sore inside/around mouth	☐ Sinus Trouble	☐ Tonsillitis	☐ Herpes (Oral)
☐ TMJ/Myofacial Muscle discomfort	☐ Glaucoma	☐ Sleep Apnea	☐ Bruxism/ Teeth Grinding

Cardiovascular

☐ High Blood Pressure	☐ High Cholesterol	☐ Stroke	☐ Chest Pain
☐ Heart Attack/Failure	☐ Angina	☐ Congenital Heart Condition	☐ Artificial Heart Valve
☐ Anticoagulant Therapy	☐ Other Heart Condition		

If yes for other heart condition, please describe:	◯ Yes ◯ No	If yes

Hematologic/Lymphatic

☐ Prolonged Bleeding	☐ Anemia	☐ Hemophilia	☐ Other Bleeding Disorder

Endocrine/ Allergy/Immunologic

☐ Diabetes	☐ Thyroid Condition	☐ Hay Fever/ Allergy	☐ Anaphylaxis
☐ Immunocompromsied			

Respiratory

☐ Asthma	☐ Fequent Cough	☐ Tuberculosis (Treatment Completed)	☐ Tuberculosis (Active)
☐ Tuberculosis (PPD+ due to Vaccine but no	☐ Other Respiratory Condition		

Bone/Joints

☐ Osteoporosis	☐ Artificial Joints/Implants	☐ Arthritis/Gout	

Cancer/Tumor/ Neoplasm

☐ History of Head and Neck Cancer	☐ Radiation Treatment	☐ Chemotherapy	☐ History of Other Cancer
☐ Benign Tumor			

GI/Liver/Kidney

☐ Hepatitis B	☐ Hepatitis C	☐ Hepatitis (Other)	☐ Other Liver Disease
☐ Kidney Problem	☐ Stomach Reflux	☐ Stomach/GI Ulcer	☐ Other GI Condition

History or Current Bacterial/Viral Infection

☐ AIDS/HIV+	☐ Venereal Disease	☐ Other Infectious Disease (Treatment Comp	☐ Other Current Infection

Psychiatric

☐ Epilepsy or Seizures	☐ Fainting Spells/Dizziness	☐ Frequent Headaches	☐ Psychiatric Care

Have you ever had any serious illness not listed	☐	If yes

For Women

Do any of following condition apply to you?

☐ Pregnant/ Trying to get Pregnant	☐ Nursing	☐ Taking Oral Contraceptive

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:___________

For Official Use only

Pt is required to take antibiotic prior to dental visit	◯ Yes ◯ No	If yes