Dental Artistry
BY DR. CHOI

HEALTH & DENTAL HISTORY

Name ______ **Date** ______

Have you been under the care of a medical doctor during the past five years? ☐ Yes ☐ No

If yes, reason ______

Name of M.D. ______ **Phone** ______

List of medications you take including aspirin and nutritional supplements:

______

Have you had an adverse reaction to any medications? ☐ Yes ☐ No **If yes, list and describe below:**

______

Allergies ☐ Yes ☐ No
List ______
Heart Disease/Surgery ☐ Yes ☐ No
Describe ______
High Blood Pressure ☐ Yes ☐ No
Stroke ☐ Yes ☐ No
Asthma/Breathing Problem ☐ Yes ☐ No
Emphysema/Lung Cancer ☐ Yes ☐ No
Hepatitis/Liver Disease ☐ Yes ☐ No
Joint Replacement, *If yes, when?* ☐ Yes ☐ No
______
Kidney Disease ☐ Yes ☐ No
Cancer, *If yes, describe below:* ☐ Yes ☐ No
______
Epilepsy/Seizures ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
H.I.V. ☐ Yes ☐ No
Neurological Disorder ☐ Yes ☐ No
Psychiatric/Psychological issue ☐ Yes ☐ No
Fainting/Dizziness ☐ Yes ☐ No
Bleeding Problem ☐ Yes ☐ No
Glaucoma/Eye Problem ☐ Yes ☐ No
Have you taken Bisphosphonates ☐ Yes ☐ No
such as Fosamax, Boniva or other? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
How many alcohol drinks per week? ______
Do you use recreational drugs ☐ Yes ☐ No
Insomnia/Frequent Walking ☐ Yes ☐ No
Ear Congestion ☐ Yes ☐ No
Ringing Ears/Tinitis ☐ Yes ☐ No

Headaches/Migraines ☐ Yes ☐ No
Difficulty Swallowing ☐ Yes ☐ No
Snoring/Sleep Apnea ☐ Yes ☐ No
Neck pain ☐ Yes ☐ No
Posture Problems ☐ Yes ☐ No
Do you see a chiropractor ☐ Yes ☐ No
Tingling Arms/Fingers ☐ Yes ☐ No
Facial Pain ☐ Yes ☐ No
Jaw Pain ☐ Yes ☐ No
Jaw Popping/Jaw Joint Noise ☐ Yes ☐ No
Limited Jaw Opening ☐ Yes ☐ No
Loose Teeth ☐ Yes ☐ No
Jaw Clenching/Teeth Grinding ☐ Yes ☐ No
Sensitive Teeth ☐ Yes ☐ No
Difficulty Chewing ☐ Yes ☐ No
Bite Problem ☐ Yes ☐ No
Trigeminal Neuralgia ☐ Yes ☐ No
Have you had orthodontics? ☐ Yes ☐ No
Crowded tongue ☐ Yes ☐ No
Does your food pack between teeth? ☐ Yes ☐ No
Do your gums bleed? ☐ Yes ☐ No
Does your breath concern you? ☐ Yes ☐ No
Other problems not listed here? ☐ Yes ☐ No
If yes, describe ______

WOMEN ONLY:
Any chance you might be pregnant? ☐ Yes ☐ No
Are you planning a pregnancy? ☐ Yes ☐ No
Are you nursing ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency who may release such information to you. I will notify the doctor of changes in my health and medication.

______ ______

PATIENT SIGNATURE (signing your name on the line serves as your signature.) **DATE**