PRINT

Duke N. Bui, DDS, PS

MEDICAL HISTORY

Patient Name _____ Date of Birth _____
Name of Your Physician _____ Physician's Office Phone _____
Are you having any health problems?.....☐Yes ☐No If Yes, explain _____
_____
Have you been hospitalized in the past two years?....☐Yes ☐No If Yes, explain _____
_____
Do you bleed excessively when cut?.....☐Yes ☐No
Do you smoke?.....☐Yes ☐No If Yes, how much? _____
Please list all medications you are currently taking, including vitamins. _____
_____
_____
Do you have, or have you had, any of the following (Please mark "X" all that apply):

☐Heart Disease	☐Heart Murmur	☐Cancer History	☐AIDS or HIV+
☐High Blood Pressure	☐Diabetes	☐Liver Disease	☐Asthma
☐Mitral Valve Prolapse	☐Stroke	☐Kidney Disease	☐Tuberculosis
☐Rheumatic Fever	☐Epilepsy	☐Hepatitis/Jaundice	☐Ulcers
☐Joint Replacement or Implant	☐Blood Thinning Medicine	☐Herpes	☐Arthritis
☐Cardiac Pacemaker	☐Respiratory Disease	☐Shunt	☐Fainting/Seizures/Epilepsy

If you are a female, are you pregnant? ☐Yes ☐No If Yes, what is the due date? _____

Are you allergic to: ☐Penicillin ☐Local Anesthetics ☐Sulfa Drugs ☐Barbiturates ☐Sedatives ☐Iodine ☐Aspirin
☐Metals (e.g. nickel, mercury, etc) ☐Latex ☐Others _____

Have you ever been told that you should be premedicated prior to dental care? ☐Yes ☐No If Yes, for what reason? _____
_____
Are you currently on bisphosphonate therapy (Aredia, Zometa)? ☐Yes ☐No If Yes, what? _____

DENTAL HISTORY

What is the reason for your dental visit today? _____
_____
When was your last dental exam? _____Cleaning? _____Full Mouth X-ray? _____

Have you had any problems with previous dental treatment?.....☐Yes ☐No _____
Have your teeth been difficult to numb in the past?.....☐Yes ☐No _____
Have you had any periodontal (gum) treatments in the past?.....☐Yes ☐No _____
Do you wear dentures or partials?.....☐Yes ☐No If Yes, how long? _____

Have you ever experienced any of the following problems in your jaw? ☐Clicking ☐Joint or ear pain ☐Chewing difficulty
☐Frequent headaches ☐Clench or grind your teeth ☐Others _____

Are you unhappy with the color or appearance of your teeth?.....☐Yes ☐No _____
Are there old fillings/crowns that you don't like looking at?.....☐Yes ☐No _____
What would you like to change the most in the appearance of your teeth? _____

PLEASE READ AND SIGN

The above medical history is accurate to the best of my knowledge. I consent to dental procedures, dental photographs, radiographs, and administration of such drugs and/or anesthetics which are necessary for the treatment of the above named patient.

Sign _____ Date _____

1. Update _____ Initial _____ Date _____
2. Update _____ Initial _____ Date _____
3. Update _____ Initial _____ Date _____
4. Update _____ Initial _____ Date _____