HEALTH HISTORY

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions don't hesitate to ask. Thank you, Drs. Jeannie and Sung Ju.

Patient Name: _____ Birth Date: _____

I. CIRCLE APPROPRIATE ANSWER (leave blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why? _____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam? _____ Date of last dental exam? _____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7.	Yes	No	Chest pain (angina)?	18.	Yes	No	Dizziness?
8.	Yes	No	Swollen ankles?	19.	Yes	No	Ringing in ears?
9.	Yes	No	Shortness of breath?	20.	Yes	No	Headaches?
10.	Yes	No	Recent weight loss, fever, night sweats?	21.	Yes	No	Fainting spells?
11.	Yes	No	Persistent cough, coughing up blood?	22.	Yes	No	Blurred vision?
12.	Yes	No	Bleeding problems, bruising easily?	23.	Yes	No	Seizures?
13.	Yes	No	Sinus problems?	24.	Yes	No	Excessive thirst?
14.	Yes	No	Difficulty swallowing?	25.	Yes	No	Frequent urination?
15.	Yes	No	Diarrhea, constipation, blood in stools?	26.	Yes	No	Dry mouth?
16.	Yes	No	Frequent vomiting, nausea?	27.	Yes	No	Jaundice?
17.	Yes	No	Difficulty urinating, blood in urine?	28.	Yes	No	Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29.	Yes	No	Heart disease?	42.	Yes	No	Tumors, cancer?
30.	Yes	No	Heart attack, heart defects?	43.	Yes	No	Radiation therapy?
31.	Yes	No	Heart murmurs?	44.	Yes	No	Chemotherapy?
32.	Yes	No	Rheumatic fever?	45.	Yes	No	HIV/AIDS?
33.	Yes	No	Stroke, hardening of arteries?	46.	Yes	No	Arthritis, rheumatism?
34.	Yes	No	High blood pressure?	47.	Yes	No	Eye disease?
35.	Yes	No	Prosthetic heart valve	48.	Yes	No	Skin disease?
36.	Yes	No	Pacemaker?	49.	Yes	No	Anemia?
37.	Yes	No	Asthma, TB, emphysema, other lung disease?	50.	Yes	No	Herpes?
36.	Yes	No	Hepatitis, other liver disease?	51.	Yes	No	Venereal disease?
37.	Yes	No	Stomach problems, ulcers?	52.	Yes	No	Kidney, bladder disease?
38.	Yes	No	Thyroid disease?	53.	Yes	No	Hospitalization?
39.	Yes	No	Diabetes?	54.	Yes	No	Surgeries?
40.	Yes	No	Artificial joint?	55.	Yes	No	Blood transfusions?
41.	Yes	No	Pre-medication required by physician?	56.	Yes	No	Contact lenses?

IV. ARE YOU ALLERGIC OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING:

57.	Yes	No	Local anesthetics ("Novocaine")	61.	Yes	No	Sulfa drugs?
58.	Yes	No	Penicillin?	62.	Yes	No	Reaction to metals?
59.	Yes	No	Aspirin, acetaminophen or ibuprofen?	63.	Yes	No	Latex or rubber dam?
60.	Yes	No	Codeine or other narcotics?	64.	Yes	No	Other _____

V. ARE YOU TAKING:

61.	Yes	No	Recreational drugs?	63.	Yes	No	Tobacco in any form?
62.	Yes	No	Drugs, medications, over-the-counter medicines, natural remedies?	64.	Yes	No	Alcohol?

Please list: _____
_____

VI. WOMEN ONLY:

65.	Yes	No	Are you or could you be pregnant or nursing?	66.	Yes	No	Taking birth control?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please explain: _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medications:

Patient's signature: _____ Date: _____
Doctor's signature: _____ Date: _____