DENTAL HISTORY

PATIENT NAME		
BIRTHDATE		MEDICAL ALERT (FOR OFFICE USE)

Welcome! *Our goal is to provide the most appropriate dental care based on individual need after consultation between doctor and patient. In order to facilitate this, please fill out this form on both sides.*

All information is completely confidenital.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

_____

_____

Are you accustomed to having your teeth numb for dental treatment? _____

How often do you have dental examinations? _____

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

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Have you noticed any mouth odors or bad tastes? Yes No
Do you frequently get cold sores, blisters or any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No
Have you noticed any loose teeth or change in your bite? Yes No
Does food tend to become caught in between your teeth? Yes No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
Mouth breathe while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Smoke/chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty in opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? Yes No

If yes, please describe _____

_____

We will strive to provide your care in the most convenient and comfortable way possible. Please let us know if there is anything else about your dental treatment that we can help you with.

Comments: _____

_____

(Please complete other side)

MEDICAL HISTORY

PATIENT NAME		
BIRTHDATE	GENDER: M/F	MEDICAL ALERT (FOR OFFICE USE)

1. Health Care Providers: (Name, Town, Phone) (Other than Dr. Sung)

_____

_____

2. Have you been under the care of a medical doctor i.e.,health care practitioner or chiropractor during the past two years? ..... Yes No
   If yes, for what? _____

   _____
3. Have you been an in/out patient in the hospital during the past 5 years? ..... Yes No
   Why? _____
4. Are you taking any medication, drugs, herbal or dietary supplements currently? ..... Yes No
   If yes, please list name and dosage: _____

   _____

   _____
5. Are you aware of having an allergic **(or adverse reaction)** to any medication or substance? ..... Yes No
   If yes, please list: _____
6. In order for us to provide you with the most appropriate dental care and correctly advise you regarding your dental health please carefully consider each of the conditions listed below. Indicate which of the following you have had, or have at the present time. It is important that you provide accurate answers to each of the following...Circle "yes" or "no" to each item.

Conditions that may require medication before dental treatment:			**General Health:**			**General Health Cont:**		
Heart Murmur	Yes	No	Arthritis	Yes	No	Psychiatric/Psychological Care	Yes	No
Mitral Valve Prolapse	Yes	No	High Cholesterol	Yes	No	Neurological Disorders	Yes	No
Artifical Heart Valve	Yes	No	Cortisone Medicine	Yes	No	Drug or Alcohol Addiction	Yes	No
Artifical Joints (hip, knee, etc.)	Yes	No	Venereal Disease	Yes	No	**Respiratory:**		
Organ Transplant	Yes	No	H.I.V. Positive	Yes	No	Emphysema	Yes	No
Intra-vascular Access Devices/Stent	Yes	No	A.I.D.S.	Yes	No	Chronic Cough	Yes	No
Rheumatic Fever	Yes	No	Swollen Ankles	Yes	No	Tuberculosis	Yes	No
Heart Conditions:			Stroke	Yes	No	Asthma	Yes	No
Surgery Disease,/Attack	Yes	No	Diet (Special/Restricted)	Yes	No	Sinus Trouble	Yes	No
Chest Pain	Yes	No	Cosmetic Surgery	Yes	No	**Allergies:**		
Congenital Heart Disease	Yes	No	Kidney Trouble	Yes	No	Hay Fever	Yes	No
High Blood Pressure	Yes	No	Ulcers	Yes	No	Latex Sensitivity	Yes	No
Arterial Sclerosis	Yes	No	Diabetes	Yes	No	Hives	Yes	No
Pacemaker/Defibrillator	Yes	No	Thyroid Problems	Yes	No	Environmental/Food/Chemical Allergies	Yes	No
Cancer:			Epilepsy or Seizures	Yes	No	(Please list)		
Tumors	Yes	No	Developmentally Disabled	Yes	No	**Blood Disorders:**		
Radiation Therapy	Yes	No	Glaucoma	Yes	No	Blood Transfusion	Yes	No
Chemotherapy	Yes	No	Contact lenses	Yes	No	Anemia	Yes	No
			Cold Sores/Fever Blisters/Canker Sores	Yes	No	Hemophilia	Yes	No
			Liver Disease	Yes	No	Sickle Cell Disease	Yes	No
			Jaundice	Yes	No	Bruise Easily	Yes	No
			Fainting or Dizzy Spells	Yes	No	Hepatitis (any form, please list)	Yes	No
			Nervous/Anxious	Yes	No			

7. Have you lost or gained more than 10 pounds in the last year? ..... Yes No
8. Please list any disease, condition or problem not listed above: _____

   _____
9. **Women.** Are you: **Pregnant?** ❑ Yes, ___ Months ❑ No **Nursing?** ❑ Yes ❑ No **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 any change in my health or medication.

Patient/Guardian Signature _____ Date _____