L-H (Sam) Chang, D.M.D., P.A. **Family & Esthetic Dentistry**

Medical History

Name____ Date__________

YES NO 1. Are you having any pain or discomfort at this time?

YES NO 2. Do you feel very nervous about having dental treatment?

YES NO 3. Have you ever had a bad experience in a dental office?

4. When was your last dental visit?________________________

YES NO 5. Have you been a patient in the hospital during the past two years?

YES NO 6. Have you been under the care of a medical doctor during the past two years?

Your Physician's Name________________________________

Address________________________________

________________ Phone (______)________________

7. Are you allergic to or have you had problems taking any of the following medications?

❍ Aspirin	❍ Nitrous Oxide	❍ Valium	❍ Local Anesthetic
❍ Penicillin	❍ Erythromycin	❍ Tetracycline	❍ Codeine
❍ Sulfa drugs	❍ Other Antibiotics	❍ Other ________________	

8. Do you now have, or have you ever had any of the following?

❍ **Premedication**	❍ Emphysema	❍ HIV/AIDS	❍ **Epinephrine sensitivity**
❍ Heart failure/attack	❍ Prolonged cough	❍ Heart disease	❍ Hepatitis _____
❍ Angina	❍ Tuberculosis	❍ High blood pressure	❍ Asthma
❍ Liver disease	❍ Heart murmur	❍ Yellow jaundice	❍ Rheumatic Fever
❍ Allergies __________	❍ Drug addiction	❍ Diabetes	❍ Hemophilia
❍ Artificial heart valve	❍ Thyroid disease	❍ Venereal disease	❍ Pacemaker
❍ Radiation treatment	❍ Cold sores	❍ Chemotherapy	❍ Seizures
❍ Epilepsy	❍ Cancer	❍ Artificial joints	❍ Arthritis
❍ Anemia	❍ Fainting	❍ Stroke	❍ Cortisone medicine
❍ Psychiatric treatment	❍ Kidney disease	❍ Glaucoma	❍ Sickle cell disease
❍ Ulcer	❍ Cosmetic surgery	❍ Bruise easily	❍ Other __________

9. Are you taking any of the following medications? If yes, please give the name of the medication and dosage.

- ❍ Antibiotics or sulfa drugs________________________
- ❍ Anticoagulants (blood thinners)________________________
- ❍ Medicine for high blood pressure________________________
- ❍ Diuretics________________________
- ❍ Cortisone (steroids)________________________
- ❍ Tranquilizers________________________
- ❍ Antihistamines________________________
- ❍ Aspirin________________________
- ❍ Insulin, tolbutamide (Orinase) or similar drug________________________
- ❍ Thyroid medication________________________
- ❍ Digitalis________________________
- ❍ Nitroglycerin________________________
- ❍ Other drugs for heart condition________________________
- ❍ Weight control medicine________________________
- ❍ Immunosupressants________________________
- ❍ Birth control pill________________________
- ❍ Other________________________

Please continue filling out this form on the reverse side

YES NO 10. Have you ever taken fenfluramine (Pondimin, "phen-fen") or dexfenfluramine (Redux)?

YES NO 11. When walking up stairs, do you ever have to stop because of pain in your chest?

YES NO 12. Have you lost or gained more than ten pounds during the past year?

YES NO 13. Are you on a special diet?

YES NO 14. Do you have any disease or condition not listed?

YES NO 15. Are you pregnant or nursing?

Please add anything you feel is important:____

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CONSENT:
The undersigned hereby authorizes the doctor to obtain any necessary radiographs, study models, photographs, or other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I understand that these needs will be discussed with me and a plan to maintain all of my teeth for all of my life in optimum health, comfort, function and esthetics will be developed.

Patient's signature____ Date__________

Parent or responsible party____ Date__________

Medical History Updates

Date: ______________________________ (To be completed by the patient or patient's agent)

I have reviewed my/the patient's *Medical History*, dated ____________________. My/the patient's medical status and general health have changed as follows (if no change, write "NO CHANGE"):

____

____

____

Signature of person completing this update: __________________________________

If other than the patient, include relationship: ________________________________

Examining dentist's comments: ____

____

Update reviewed by: ____

Date: ______________________________ (To be completed by the patient or patient's agent)

I have reviewed my/the patient's *Medical History*, dated ____________________. My/the patient's medical status and general health have changed as follows (if no change, write "NO CHANGE"):

____

____

____

Signature of person completing this update: __________________________________

If other than the patient, include relationship: ________________________________

Examining dentist's comments: ____

____

Update reviewed by: ____