MEDICAL & DENTAL HISTORY

In order to provide the highest quality of dental treatment, please answer the following questions. All the information provided to us will remain confidential.

Name:	**Date of Birth (MM/DD/YY):**	
Address:	**City:**	**Postal Code:**
Home Phone #: **Please circle preferred contact #**	**Work/Mobile phone #:**	
Email:	**General Dentist:**	
Emergency contact: **Phone #:**	**Do you have dental insurance?** ¦**Yes** ¦**No**	

For office use only: **-Blood Pressure:**
-Pulse:

Medical Health:

Are you currently taking any medications? ¦**Yes** ¦**No**	**List of Medications:**
Name of Family Doctor:	**Last Physical Exam:**

Are you Allergic to:	**Penicillin:**	¦**Yes**	¦**No**	**Local Anesthetic:**	¦**Yes**	¦**No**		
	Codeine:	¦**Yes**	¦**No**	**Any other Medications:**	¦**Yes**	¦**No**	**If yes, please specify:**	

Have you had any of the following conditions?

Heart disease	¦**Yes** ¦**No**	**Diabetes (type I / II)**	¦**Yes** ¦**No**
Heart murmur	¦**Yes** ¦**No**	**Epilepsy**	¦**Yes** ¦**No**
Rheumatic fever	¦**Yes** ¦**No**	**Anemia**	¦**Yes** ¦**No**
High blood pressure	¦**Yes** ¦**No**	**HIV/AIDS**	¦**Yes** ¦**No**
Low Blood pressure	¦**Yes** ¦**No**	**Prosthetic joints**	¦**Yes** ¦**No**
Hepatitis/Liver disease	¦**Yes** ¦**No**	**Osteoporosis**	¦**Yes** ¦**No**
Tuberculosis/lung disease	¦**Yes** ¦**No**	**Ulcers/Digestive problems**	¦**Yes** ¦**No**
Asthma / hay Fever	¦**Yes** ¦**No**	**Radiation therapy/Chemotherapy**	¦**Yes** ¦**No**
Cancer **If yes, please specify:**	¦**Yes** ¦**No**	**Are you subject to prolonged bleeding?**	¦**Yes** ¦**No**

Women:

Are you pregnant or anticipating pregnancy?	¦**Yes** ¦**No**	**Are you nursing?** ¦**Yes** ¦**No**	
Are you taking oral contraceptives?	¦**Yes** ¦**No**		

Oral Health:

Do your gums bleed when brushing/flossing?	¦**Yes** ¦**No**	**Are your teeth sensitive to hot/cold?**	¦**Yes** ¦**No**
Do your gums feel tender or swollen?	¦**Yes** ¦**No**	**Are any teeth loose?** **Which one (s)?**	¦**Yes** ¦**No**
Do you clench or grind your teeth? **Do you wear a nightguard?**	¦**Yes** ¦**No** ¦**Yes** ¦**No**	**How often do you brush?**	**How often do you floss?**
Do you smoke? **How much?**	¦**Yes** ¦**No**	**When was your last dental cleaning?** _____	**How often do you get your teeth cleaned?** _____

_____ _____

PATIENT or Guardian Signature **Dr. W. Paul Jang / Dr. Cynthia Yee**

Date: _____