Vi Truong-Mai, D.D.S.

HEALTH HISTORY

Patient's Name _____ Date of Birth _____

Why have you come to see us today? (e.g., pain, checkup, etc.) _____

Previous Dentist _____ Last Visit _____ Date of last cleaning _____

Reasons for changing dentists: _____

Have you had any problems with past dental treatment? _____

Have you ever had any prolonged bleeding following extractions or surgery? ☐ Yes ☐ No

Are you nervous about seeing a dentist? ☐ Yes! ☐ No If Yes, please tell us why. _____

How often do you brush? _____ Do you floss? ☐ Yes ☐ No How often? _____

PATIENT'S MEDICAL HISTORY

I consider my health to be *(Please check one):* ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have or have you had any of the following? *Please circle Y for yes or N for no.*

1. **Y N** Heart Disease
2. **Y N** Heart Murmur
3. **Y N** Stroke
4. **Y N** Heart Attack
5. **Y N** Chest Pain
6. **Y N** Cardiac Pacemaker
7. **Y N** Congenital Heart Lesions
8. **Y N** Rheumatic Fever
9. **Y N** Abnormal Blood Pressure
10. **Y N** Anemia
11. **Y N** Prolonged Bleeding Disorder
12. **Y N** Tuberculosis or Lung Disease
13. **Y N** Asthma
14. **Y N** Hay Fever
15. **Y N** Sinus Trouble
16. **Y N** Epilepsy / Seizures
17. **Y N** Ulcers, Stomach Problems
18. **Y N** Implants / Artificial Joints. Hip-Knee_____ Other_____
19. **Y N** I smoke or use chewing tobacco. If yes, how much per day? How many years?
20. **Y N** I have consumed alcohol within the last 24 hours.
21. **Y N** I usually take an antibiotic prior to dental treatment.
22. **Y N** Have you ever taken Fen-Phen or Redux?
23. **Y N** I have had major surgery. Year_____ Type_____ Year_____ Type_____
24. **Y N** Do you have any other medical problem or medical history NOT listed on this form? _____
25. **Y N** Liver Disease
26. **Y N** Jaundice
27. **Y N** Hepatitis Type _____
28. **Y N** Diabetes
29. **Y N** Excessive Urination and/or Thirst
30. **Y N** Infectious Mononucleosis ("Mono")
31. **Y N** Herpes
32. **Y N** Arthritis, Rheumatism
33. **Y N** Sexually Transmitted / Venereal Disease
34. **Y N** Kidney Disease
35. **Y N** Tumor or Malignancy
36. **Y N** Cancer / Chemotherapy
37. **Y N** Radiation Therapy
38. **Y N** History of Drug Addiction
39. **Y N** AIDS
40. **Y N** Immune Suppressed Disorders
41. **Y N** Hearing Loss
42. **Y N** Fainting Spells
43. **Y N** Glaucoma, Eye Disease
44. **Y N** History of Emotional or Nervous Disorders
45. **Y N** Thyroid Problem

WOMEN:

46. **Y N** Are you taking birth control medication?
47. **Y N** Are you or could you be pregnant or nursing?

Are you allergic to any of the following?
Please circle Y for yes or N for no

1. **Y N** Aspirin
2. **Y N** Sulfa Drugs / Sulfites / Sulfides
3. **Y N** Penicillin
4. **Y N** Codeine
5. **Y N** Latex, Metals, Plastics
6. **Y N** Local Anesthetics (Novocaine)
7. **Y N** Other Medications Which ones?_____

_____

Please list all medications you are currently taking:

_____

_____

_____

Are you being treated by a physician now? _____

Physician's Name _____ Phone _____

Address _____ FAX _____

To the best of my knowledge, I have answered every question completely and accurately.

Medical health reviewed by:

X _____ / / _____
Doctor's Signature *Date*

X _____ / / _____
Patient's Signature *Date*

X _____ / / _____
If Patient is a Minor, Parent/Guardian's Signature *Date*