Eric S. Yao, DDS, MAGD

Dedicated Dental Care for Your Family's Good Health

DENTAL & MEDICAL INFORMATION

Name (Please Print)_____

Reason for today's visit _____ Date of last dental care_____

Former Dentist _____ Date of last dental X-rays_____

Former Dentist Phone No._____Address_____

Are you currently under the care of a medical doctor? Yes No If yes, please explain_____

Physician (Medical Doctor) Names_____ Phone No. _____

Address_____

Recent surgeries/Hospitalization _____

Prescription Medications:	Over the Counter Medications:
1. _____taking for_____	1._____taking for_____
2._____taking for_____	2._____taking for_____
3._____taking for_____	3._____taking for_____
4._____taking for_____	4._____taking for_____

DENTAL HEALTH HISTORY

PLEASE MARK ANY THAT APPLY	*YES*	*NO*		*YES*	*NO*
Are you apprehensive about dental treatment?	_____	_____	Chew on one side of your mouth?	_____	_____
Have you had problems with previous dental treatment?	_____	_____	Lip or cheek biting?	_____	_____
If yes, please explain_____			History of periodontal problems	_____	_____
Do you smoke cigarettes, pipes or cigars?	_____	_____	Do you gag easily?	_____	_____
Clicking/popping jaw/jaw pain or tiredness?	_____	_____	Do you wear dentures?	_____	_____
Does food catch between your teeth?	_____	_____	Do you clench or grind?	_____	_____
Are you dissatisfied with the appearance of your teeth?	_____	_____	Do you have sensitivity to sours?	_____	_____
Do you have sensitivity to hot/cold foods or liquids?	_____	_____	Do you have sensitivity to sweets?	_____	_____
Do you have slow healing sores in your mouth?	_____	_____	Do you have loose teeth	_____	_____
Does your jaw get stuck so you can't open easily?	_____	_____	Do you have broken fillings	_____	_____

MEDICAL HEALTH HISTORY

PLEASE CHECK ANY THAT APPLY

Asthma/Allergy

_____Asthma _____Hay Fever _____Use Inhaler _____Allergies

Allergic Reactions to

_____Latex or Rubber Dam _____Tetracycline Allergy _____Erythromycin Allergy

_____Penicillin Allergy _____Sulfa Drugs Allergy _____Dental Local Anesthetics (e.g. Novocaine) Allergy

_____Aspirin, Acetaminophen, or Ibuprofen Allergy _____Reaction to Metals

_____Codeine, Demerol, or Other Narcotics _____Barbiturates, Sedatives, or Sleeping Pills

Blood Problems

_____Blood Diseases _____Easy Bruising _____Excessive Bleeding _____High Blood Pressure _____Hemophilia

_____Previous Blood Transfusion _____Low Blood Pressure _____Anemia

MEDICAL HEALTH HISTORY (continued)

PLEASE CHECK ANY THAT APPLY

Heart Problems

_____Chest Pain/Angina
_____Blood Pressure Problem
_____Congenital Heart Defect
_____Heart murmur
_____Heart Disease
_____Heart Attack
_____Heart Valve Problem
_____Taking Heart Medication
_____Artificial Heart Valve
_____ Heart Surgery
_____ Pacemaker _
_____ Mitral Valve Prolapse
_____ Stroke
_____ Shortness of Breath
_____Rheumatic Fever
_____Others _____

Women Only

_____ Reached Menopause
_____ Pregnant
If Yes, Due Date_____
_____ Nursing
_____Taking Contraceptives or Other Hormones

Liver Disease

_____Hepatitis _____Jaundice
_____Liver Disorder

STD

_____Aids _____HIV
_____Herpes or Other STD

Thyroid Disease

_____ Thyroid Problems
_____ Hypothyroid/Hyperthyroid

Joint or Bone Problems

_____Artificial Joints _____Arthritis _____Rheumatism _____Others_____

Other Health Conditions

_____Acid Reflux
_____Breathing Difficulty
_____Cancer
_____Colitis
_____Diabetes
_____Dizziness
_____Swollen Glands
_____Ulcers
_____Drug/Alcohol Abuse
_____Dry Mouth
_____Emphysema
_____Epilepsy
_____Fainting
_____Frequent Headaches
_____Tuberculosis
Others_____
_____Frequent Mouth Sores
_____Glaucoma
_____Growths
_____Hospitalized
_____Kidney Problems
_____Mental Disorders
_____Tumors
_____Nervous Disorders
_____Persistent Cough
_____Radiation Treatment
_____Respiratory Problems
_____Shingles
_____Sinus Problems
_____Tobacco Use

Have you ever taken in oral form or had I.V. bone density medications (for example Fosamax, Boniva, etc.)

If so, when did you take medication and for how long_____

Do you drink alcohol?

If so, how much/how often _____

FOR OFFICE USE ONLY

Initial Blood Pressure:_____ Pulse:_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for errors or omissions that I may have made in the completion of this form. Furthermore, I grant permission to Eric S. Yao, DDS, PLLC and Staff to perform treatment as deemed professionally necessary. When local anesthetic is administered, I understand that the risks can involve heart palpitation, allergic reaction, hematoma, parasthesia, and drug cross reaction. I further allow the release of my dental records from Dr. Yao to individuals involved in my dental care. I authorize individuals involved in my dental care to release to Dr. Yao any information pertaining to my dental care.

_____ _____

Patient / Guardian Signature **Date** **Provider Signature** **Dat**