HEALTH HISTORY FORM FOR PATIENTS OF DR. CHANG

Date ______________________

Name ____ Date of Birth ______________

Address ____ Telephone ________________

Business Address ____ Business Phone ______________

Soc. Sec. No. ______________

PATIENT MEDICAL HISTORY

Physician ____________________________ Office Phone ____________ Home Phone __________

Approximate date of last physical examination ________________________

		YES	NO
1.	Are you taking aspirin or any blood thinners ?	☐	☐
2.	Are you under any medical treatment now?	☐	☐
	Please List: ______________________________		
3.	Have you had any major operations?	☐	☐
	Please List: ______________________________		
4.	Have you ever had any adverse reaction to any metals?	☐	☐
5.	Have you ever had any adverse reaction to latex or any rubber products?	☐	☐
6.	Have you ever had a serious accident involving head injuries ?	☐	☐
7.	Have you had any adverse response to any drugs including penicillin ?	☐	☐
8.	Has a physician ever informed you that you had: Heart Ailment?	☐	☐
9.	High Blood Pressure?	☐	☐
10.	Have you ever been told you have a heart murmer or mitral valve prolapse ?	☐	☐
11.	Respiratory Disease?	☐	☐
12.	Diabetes?	☐	☐
13.	Frequent urination, thirst or hunger?	☐	☐
14.	Rheumatic Fever?	☐	☐
15.	Rheumatism or Arthritis?	☐	☐
16.	Tumors or Growths?	☐	☐
17.	Any Blood Disease?	☐	☐
18.	Any Liver Disease?	☐	☐
19.	Any Kidney Disease?	☐	☐
20.	Any Stomach or Intestinal Disease?	☐	☐
21.	Any Venereal Disease?	☐	☐
22.	Tested HIV positive or AIDS Related Complex?	☐	☐
23.	Yellow Jaundice or Hepatitis?	☐	☐
24.	Do you have night sweats accompanied by weight loss or cough?	☐	☐
25.	Are you on a diet at this time?	☐	☐
26.	Are you now taking drugs or medications?	☐	☐

Please List: (Name of medication and dose).

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	YES	NO
27. Are you allergic to any known materials resulting in hives, asthma, eczema, etc.?	☐	☐
28. Are you in general good health at this time?	☐	☐
29. Have any wounds healed slowly or presented other complications?	☐	☐
30. Are you pregnant?	☐	☐
31. Do you have a history of fainting or seizures?	☐	☐
32. Have you ever had any X-RAY TREATMENTS (other than diagnostic)?	☐	☐

PATIENT DENTAL HISTORY

33. Do you have sensitivity to Hot, Colds, or Sweets?	☐	☐
34. Do you have pain in or near your ears?	☐	☐
35. Do you have any unhealed injuries or inflamed areas in or around your mouth?	☐	☐
36. Have you experienced any growth or sore spots in your mouth?	☐	☐
37. Does any part of your mouth hurt when clenched?	☐	☐
38. Have you ever had Novocaine anesthetic?	☐	☐
39. Any reactions or allergic symptoms to Novocaine?	☐	☐
40. Any difficult extractions in the past?	☐	☐
41. Prolonged bleeding following extractions in the past ?	☐	☐
42. Trench mouth?	☐	☐
43. Do you have an unpleasant odor or taste in your mouth?	☐	☐
44. Do your gums bleed?	☐	☐
45. Have you ever had instruction on the correct method of brushing your teeth?	☐	☐
46. Have you ever had instructions on the care of your gums?	☐	☐
47. Do you chew on only one side of your mouth? If so, why?	☐	☐
48. Do you at the present time have any dental complaints?	☐	☐
49. Do you habitually clench your teeth during the night or day?	☐	☐

50. When was your last full mouth X-RAY taken? ____________________Where?__________________________

51. Is any part of your mouth sore to pressures or irritants (cold, sweets, etc.)?

If so, locate____

Patient Signature____ **Date**____________________