DENTAL HISTORY

Cameron C. Cho, D.D.S. • Pamela L. Schmidt, D.D.S.

Welcome! So we may provide you with the best possible care, please complete both sides of this dental / medical history form. All information is completely confidential.

What is the reason for your dental visit? _____

Date of last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

What treatment was done at your last visit? _____

How often do you brush your teeth? _____ How often do you floss? _____

Do you use any other dental devices? Please list _____

Do you have any dental problems now? Yes / No If yes, please describe _____

Previous dentist's name _____ City _____ Telephone _____

Do you have sensitivity to:

Yes / No Hot or Cold
Yes / No Sweets
Yes / No Biting or Chewing
Yes / No Opening or Closing

Are you aware that you:

Yes / No Clench or grind your teeth while awake or asleep
Yes / No Bite your lips or cheeks regularly
Yes / No Hold foreign objects with your teeth
Yes / No Mouth breathe while awake or asleep
Yes / No Have tired jaws, especially in the morning
Yes / No Smoke or chew tobacco

Have you experienced or had any of the following:

Yes / No Orthodontic treatment
Yes / No Oral surgery
Yes / No Periodontal or gum treatment
Yes / No Your teeth ground or bite adjusted
Yes / No A bite plate or mouth guard
Yes / No A serious injury to the mouth or head
Please describe below

Yes / No Clicking or popping of the jaw
Yes / No Pain in the jaw joint, ear or side of face
Yes / No Difficulty opening or closing the mouth
Yes / No Headaches, neckaches or shoulder aches
Yes / No Sore muscles in the face, neck or shoulders

Yes / No Have you noticed any mouth odors or bad tastes
Yes / No Do you get cold sores, blisters or any other oral lesions
Yes / No Do your gums bleed, hurt or swell
Yes / No Have your parents experienced gum disease or tooth loss
Yes / No Have you noticed any loose teeth or change in your bite
Yes / No Does food tend to become caught between your teeth

Please comment in the space to the right
Yes / No Would you like to keep all your teeth all of your life
Yes / No Do you feel nervous about dental treatment
If yes, what is your biggest concern
Yes / No Have you ever had an upsetting dental experience
If yes, please describe

If you could change anything about your teeth or smile, what would that be?

Date	Comments	Signed Pt/DDS	Date	Comments	Signed Pt/DDS

MEDICAL HISTORY

Cameron C. Cho, D.D.S. • Pamela L. Schmidt, D.D.S.

Name: _____ **Date:** _____

Yes / No **Is your general health good? If NO, explain** _____

Yes / No **Has there been a change in your health within the last year? If YES, explain** _____

Yes / No **Have you gone to the hospital or emergency room or had a serious illness in the last three years? If YES, explain** _____

Yes / No **Are you being treated by a physician now? If YES, explain** _____

Date of last medical exam _____ **Reason for exam** _____ _____

Have you experienced any of the following? *(Please circle Yes or No for each)*

Yes / No	Chest pain (angina)	Yes / No	Coughing up blood	Yes / No	Ringing in ears	Yes / No	Dry mouth
Yes / No	Fainting spells	Yes / No	Bleeding problems	Yes / No	Headaches	Yes / No	Excessive thirst
Yes / No	Recent significant weight loss	Yes / No	Blood in urine	Yes / No	Dizziness	Yes / No	Difficulty swallowing
		Yes / No	Blood in stools	Yes / No	Blurred vision	Yes / No	Swollen ankles
Yes / No	Fever	Yes / No	Diarrhea or constipation	Yes / No	Bruise easily	Yes / No	Joint pain or stiffness
Yes / No	Night sweats	Yes / No	Frequent urination	Yes / No	Frequent vomiting	Yes / No	Shortness of breath
Yes / No	Persistent cough	Yes / No	Difficulty urinating	Yes / No	Jaundice	Yes / No	Sinus problems

Have you had or do you have any of the following? *(Please circle Yes or No for each)*

Yes / No	Heart disease	Yes / No	Hardening of arteries	Yes / No	Radiation	Yes / No	Hepatitis
Yes / No	Family history of heart disease	Yes / No	High blood pressure	Yes / No	Arthritis, rheumatism	Yes / No	Sexual transmitted disease
		Yes / No	Seizures	Yes / No	Emphysema or other lung disease		
Yes / No	Heart attack	Yes / No	Cosmetic surgery			Yes / No	Herpes
Yes / No	Artificial joint or valve	Yes / No	Surgeries	Yes / No	Kidney or bladder disease	Yes / No	Canker or cold sores
Yes / No	Stomach problems or ulcers	Yes / No	Hospitalization			Yes / No	Anemia
		Yes / No	Diabetes	Yes / No	Stroke	Yes / No	Liver disease
Yes / No	Heart defects	Yes / No	Family history of diabetes	Yes / No	Eating disorders	Yes / No	Eye disease
Yes / No	Heart murmurs			Yes / No	Osteoporosis	Yes / No	Transplants
Yes / No	Rheumatic fever	Yes / No	Tumors or cancer	Yes / No	Thyroid disease	Yes / No	Tuberculosis
Yes / No	Skin disease	Yes / No	Chemotherapy	Yes / No	Asthma		

This information will not be released unless specifically authorized by patient.

Yes / No AIDS/HIV Yes / No Anxiety Yes / No Depression Yes / No Treatment for emotional condition

Are you allergic to or have you had a reaction to any of the following? *(Please circle Yes or No for each)*

Yes / No	Aspirin	Yes / No	Local anesthetic- Novocain or Xylocaine	Yes / No	Penicillin	Yes / No	Vicodin
Yes / No	Darvon			Yes / No	Food	Yes / No	Percodan
Yes / No	Codeine	Yes / No	Valium	Yes / No	Erythromycin	Yes / No	Nitrous oxide
Yes / No	Latex	Yes / No	Demerol	Yes / No	Tetracycline	Yes / No	Metal

Others: _____

Are you taking or have you taken any of the following in the last three months? *(Please circle Yes or No for each)*

Yes / No	Recreational drugs	Yes / No	Weight loss medications	Yes / No	Alcohol	Yes / No	Antibiotics
Yes / No	Over-the-counter medicines	Yes / No	Corticoid-Steroids	Yes / No	Bisphosphonate (Fosamax)	Yes / No	Supplements
		Yes / No	Tobacco in any form			Yes / No	Aspirin

Women Only *(Please circle Yes or No for each)*

Yes / No- Are you or could you be pregnant? If YES, what month?_____ Yes / No- Are you nursing? Yes / No- Are you taking birth control pills?

All patients *(Please circle Yes or No for each)*

Yes / No **Do you have or have you had any other diseases or medical problems NOT listed on this form? If YES, explain** _____

Yes / No **Have you ever been pre-medicated for dental treatment? If YES, why** _____

Yes / No **Have you ever taken Fen-Phen? If YES, when** _____

Yes / No **Is there any issue or condition that you would like to discuss with the dentist in private?** _____

Please list any medications you are taking in the space to the right: _____ _____

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my physician. In addition, I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient's Signature _____ Date _____ Dentist Signature _____ Date _____

Update

Patient Initial _____ Dentist Initial _____ Date _____ Patient Initail _____ Dentist Initial _____ Date _____

Patient Initial _____ Dentist Initial _____ Date _____ Patient Initail _____ Dentist Initial _____ Date _____