Physician's Name Phone	Yes	No No No No No No
Address	Yes Yes Yes Yes Yes Yes pills? Yes	No No No No No No No S/ No
1. Are you under the care of your physician? If yes, for what? 2. Have you been hospitalized or had surgical operation or serious illness within the past five years? 3. Are you taking any medication, drugs or controlled substances, including regular dosage of aspirin? If yes, please list name and dosage: 4. Have you ever taken prescription medication for weight loss (diet pills)? (i.e. Fen-Phen, Redux, etc.) 5. Do you smoke or chew tobacco? 6. Are you wearing contact lenses? 7. Have you lost or gained more than 10 pounds in the past year? 8. <women> Are you: Pregnant? Yes, Months/ No Nursing? Yes/ No Taking birth control 9. Are you aware of having an allergic (or adverse) reaction to any medication or substance? If yes, please list: 10. Circle and Indicate which of the following you have had, or have at present. Heart (Surgery, Disease, Attack) Ulcers Cold Sores / Fever Blisters Heart Pacemaker Diabetes Blood Transfusion Chest Pain Thyroid Problems Hemophilia Congenital Heart Disease Anemia Liver Disease Heart Murmur Chronic Cough Yellow Jaundice High / Low Blood Pressure Tuberculosis Mitral Valve Prolapse Rheumatic Fever Hay Fever Sickle Cell Disease Arthritis / Rheumatism Latex Sensitivity Bruise Easily Swollen Ankles Allergies or Hives Neurological Disorders Epilepsy or Seizures Sinus Trouble Psychiatric / Psychological</women>	Yes Yes Yes Yes Yes Yes Yes Yes Yes Pills? Yes	No No No No No No No
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Epilepsy or Seizures Sinus Trouble Psychiatric / Psychological		
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rainting of Dizzy spens Radiation Therapy sexually Transmitted Dise	ase	
Asthma Chemotherapy Glaucoma		
Leukemia Tumors Emphysema		
Stroke Hepatitis A B C (circle) Angina		
Diet (Special/Restricted) Venereal Disease Cortisone Medicine		
Artificial Joints (hip, knee, etc) A.I.D.S Artificial Heart Valve		
Kidney Diseases H.I.V. Positive Lung Problems		
I. Do you have or have you had any disease, condition, or problem not listed? If yes, please list:	Yes	No
DENTAL HISTORY Last Dental Visit and Reason		
revious Dentist's Name Phone ddress		
Do your gums bleed while brushing or flossing?	Yes	No
. Are your teeth sensitive to hot, cold, sweet or sour liquids or foods?	Yes	No
If yes, please indicate what and where:	103	140
Do you have a toothache? If yes, please indicate where:	Yes	No
Have you ever had injuries to your head, neck or jaw?	Yes	No
Do you have any jaw joint problems? (i.e. clicking, painful joints, difficulty in chewing, headaches)	Yes	No
Do you have any oral habits? (i.e. biting your finger nails or lips, pencil ends, etc)	Yes	No
Do you have a bleeding problem? (i.e. prolong bleeding following tooth extraction)	Yes	No
Have you had braces or orthodontic treatment?	Yes	No
Do you wear dentures, plates, or partials? If yes, date of placement:	Yes	No
D. Have your dentist or hygienist teach you the correct methods of brushing and flossing?	Yes	No
I. I brush my teeth times a day, and I floss times a day.		
have answered the above questions to the best of my knowledge. I understand that inaccurate or omitted i angerous to my health, and may cause adverse reaction and affect the outcome of my dental treatment. I voctor of change in my health or medication.		
atient/ Guardian Signature Date		

KA-WING CHEW, D.D.S.