Irene C. Chang, D.D.S., M.S.
Practice Limited to Endodontics

CONFIDENTIAL HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

I. CIRCLE APPROPRIATE ANSWER *(Leave blank if you do not understand the question)*

1. *Yes/No Is your general health good?*
   If NO, explain: _____
2. *Yes/No Has there been a change in your health within last year?*
   If YES, explain: _____
3. *Yes/No Have you gone to the hospital or emergency room or had a serious illness in the last three years?*
   If YES, explain: _____
4. *Yes/No Are you being treated by a physician now?*
   If YES, explain:_____

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

5. *Date of last dental exam: _____* ***Name of dentist****: _____*

   If it is different from the above, ***who refers you to our office****? _____*
6. *Yes/No Have you had problems with prior dental treatment? If YES, explain:*

   _____

7. *Yes/No Are you in pain now? If YES, explain: _____*

II. ARE YOU EXPERIENCING ANY OF THE FOLLOWING? *(Please circle)*

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

III. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? *(Please circle and explain circled area)*

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

IV. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING?
(Please circle Yes or No, if YES please explain)

Yes/No Aspirin	*Yes/No Valium*	*Yes/No Demerol*
Yes/No Vicodin	*Yes/No Codeine*	*Yes/No Percodan*
Yes/No Penicillin	*Yes/No Erythromycin*	*Yes/No Tetracycline*
Yes/No Latex	*Yes/No Food*	*Yes/No Nitrous oxide*
Yes/No Local anesthetic (Novocaine or Xylocaine)	*Yes/No Metal*	

List Other Allergies:_____

V. ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS? *(Please circle and explain circled area)*

Yes/No Recreational drugs _____ *Yes/No Over the counter medicines* _____
Yes/No Antibiotics _____ *Yes/No Bisphosphonate (Fosamax) When:* _____
Yes/No Supplements _____ *Yes/No Tobacco in any form* _____
Yes/No Aspirin *Yes/No Alcohol* *Yes/No Weight loss medications*

Please list all current medication: _____
_____

VI. WOMEN ONLY

Are you or could you be pregnant? If YES, what month? _____
Are you nursing? _____
Are you taking birth control pills? _____

VII. ALL PATIENTS *(Please circle Yes or No)*

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

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.

*Patient's Signature:*_____ *Date:* _____

*Physician's Name:*_____ *Phone Number:* _____

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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.

_____ _____ _____ _____
Signature of Patient (Parent or Guardian) ***Date*** ***Signature of Dentist*** ***Date***

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MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	***PATIENT SIGNATURE***	***CHANGES OF HEALTH HISTORY***	***DENTIST INITIALS***
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____