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Medical History

Andrew Owyong, DDS.

PATIENT NAME _____ **Birth Date** _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important inter-relationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No

If, yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No

If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No

If yes, please explain: _____

Are you taking any medications, pills or drugs? Yes No

If yes, please explain: _____

Do you take, or have you taken Phen-Fen or Redux? Yes No

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

Do you have, or have you had, any of the following?

- | | | | | | |
|------------------------|--|-------------------|--|---------------------------|--|
| AIDS/HIV Positive | <input type="radio"/> Yes <input type="radio"/> No | Artificial Joint | <input type="radio"/> Yes <input type="radio"/> No | Chemotherapy | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease | <input type="radio"/> Yes <input type="radio"/> No | Asthma | <input type="radio"/> Yes <input type="radio"/> No | Chest Pains | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Blood Disease | <input type="radio"/> Yes <input type="radio"/> No | Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes <input type="radio"/> No | Blood Transfusion | <input type="radio"/> Yes <input type="radio"/> No | Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No |
| Angina | <input type="radio"/> Yes <input type="radio"/> No | Breathing Problem | <input type="radio"/> Yes <input type="radio"/> No | Convulsions | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout | <input type="radio"/> Yes <input type="radio"/> No | Bruise Easily | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve | <input type="radio"/> Yes <input type="radio"/> No | Cancer | <input type="radio"/> Yes <input type="radio"/> No | Diabetes | <input type="radio"/> Yes <input type="radio"/> No |



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- Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pace Maker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of the Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No

If yes, please explain:

Comments:

To the best of my knowledge, the questions on this form have been answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN:

DATE: