Trang T. Le, D.D.S., Ltd.

Aesthetic & Comprehensive Dentistry

Patient Medical and Dental History

Patient Name: ______________________ Date: ____________

Although dental personnel primarily treat dental conditions, your mouth is part of your entire body. Health problems you may have or medications you may be taking could have an effect on the dentistry you will receive.

Dental History:

Primary reason for this appointment: ☐ Exam ☐ Emergency ☐ Consultation

Do you have a specific dental problem? ------------- *Please Explain:* ____________

Do you think you have active decay or gum disease? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Do you want to keep your remaining teeth? ☐ Yes ☐ No

Do you have clicking, popping, or discomfort? ☐ Yes ☐ No

Preferred Dentist or Provider: ____________

Medical History:

Are you under the care of a physician? ☐ Yes ☐ No *If yes, please explain* ____________

Have you ever been hospitalized or had major operation? ☐ Yes ☐ No *If yes, please explain* ____________

Are you taking any medications or pills, or drugs? Please List: ____________

Have you received treatment for osteoporosis? ☐ Yes ☐ No *If yes, choose med(s)* ____________

Do you use tobacco? ☐ Yes ☐ No *If yes, (check one)* ☐ Smoke ☐ Chew

Are you allergic to any of the following?

☐ Penicilin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local anestheics

Other: (Please be specific) ____________

Women: (Are you): ☐ Pregnant ☐ Nursing ☐ Taking oral contraceptives

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

☐ Angina	☐ Hemophilia	☐ Alzheimer's	☐ Kidney Problems
☐ Heart Attack	☐ Anemia	☐ Glaucoma	☐ Renal Dialysis
☐ Heart Murmur	☐ Scarlet Fever	☐ Arthritis/Gout	☐ Cancer
☐ Mitral Valve Prolaspe	☐ Asthma	☐ Artificial Joint	☐ Chemotherapy
☐ Congenital Heart Disorder	☐ Easily Winded	☐ Swelling of The Limbs	☐ Radiation Treatments
☐ Pace Maker	☐ Emphysema	☐ Cortisone Medication	☐ Leukemia
☐ Chest Pains	☐ Lung Disease	☐ Ulcers	☐ Liver Disease
☐ Irregular Heartbeat	☐ Tuberculosis	☐ Frequent Diarrhea	☐ Hepatitis A, B, or C
☐ Artifical Heart Valve	☐ Hay Fever	☐ Gastric Reflux Diesease	☐ Drug Addiction
☐ High Blood Pressure	☐ Sinus Trouble	☐ Recent Weight Loss	☐ AIDS/HIV
☐ Low Blood Pressure	☐ Frequent Headaches	☐ Eating Disorder	☐ Venereal Disease
☐ Excessive Bleeding	☐ Stroke	☐ Diabetes	☐ Shingles
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ Hypoglycemia	☐ Psychiatric Care
☐ Rheumatic Fever	☐ Epilepsy/Sezures	☐ Excessive Thirst	

Have you had any other illness not listed above? ☐ Yes ☐ No If yes, please list: ____________

Emergency Contact: ____________ Phone Number ____________

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To the best of my knowledge, I have accurately answered the questions on this form. I understand providing incorrect or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform *Dr. Trang T. Le* of any changes in medical status in a timely manner.

Signature: ____________ Date: ____________