Patrick Yee, DDS

COSMETIC AND RESTORATIVE DENTIST

Patient Name

Patient Account No.

MEDICAL HISTORY

Medical Alert

1. Physician's Name _____ Phone ( ) _____

Have you had any medical care within the past two years? _____ ☐ Yes ☐ No

Describe _____

2. Have you taken any medication or drugs during the past two years? _____ ☐ Yes ☐ No

3. Are you currently taking an medication, drugs, pills or herbal remedies, including regular dosages of aspirin? _____ ☐ Yes ☐ No

4. Have you ever taken prescription medications for weight loss (diet pills)? _____ ☐ Yes ☐ No

If yes, did you take any of the following? (Check if yes) ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other

If yes to any of the above, did you have a medical exam for heart issues? _____ ☐ Yes ☐ No

5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? _____ ☐ Yes ☐ No

6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? _____ ☐ Yes ☐ No

If yes, please specify _____

7. Have you been a patient in the hospital during the past five years? _____ ☐ Yes ☐ No

8. Indicate which of the following you have had, or have at present. Check"Yes"or"No"to each item.

Heart (Surgery, Disease, Attack) _____ ☐ Yes ☐ No

Chest Pain _____ ☐ Yes ☐ No

Congenital Heart Disease _____ ☐ Yes ☐ No

Heart Murmur _____ ☐ Yes ☐ No

High/Low Blood Pressure _____ ☐ Yes ☐ No

Mitral Valve Prolapse _____ ☐ Yes ☐ No

Artificial Heart Valve/ Pacemaker _____ ☐ Yes ☐ No

Rheumatic Fever _____ ☐ Yes ☐ No

Arthritis/Rnheumatism _____ ☐ Yes ☐ No

Cortisone Medicine _____ ☐ Yes ☐ No

Swollen Ankles _____ ☐ Yes ☐ No

Stroke _____ ☐ Yes ☐ No

Diet (Special/Restricted) _____ ☐ Yes ☐ No

Artificial Joints (Hip, Knee, etc) _____ ☐ Yes ☐ No

Kidney Trouble _____ ☐ Yes ☐ No

Ulcers _____ ☐ Yes ☐ No

Diabetes _____ ☐ Yes ☐ No

Thyroid Problems _____ ☐ Yes ☐ No

Glaucoma _____ ☐ Yes ☐ No

Contact Lenses _____ ☐ Yes ☐ No

Emphysema _____ ☐ Yes ☐ No

Chronic Cough _____ ☐ Yes ☐ No

Tuberculosis _____ ☐ Yes ☐ No

Asthma _____ ☐ Yes ☐ No

Hay Fever/Allergy/Hives _____ ☐ Yes ☐ No

Latex Sensitivity _____ ☐ Yes ☐ No

Sinus Trouble _____ ☐ Yes ☐ No

Radiation Therapy _____ ☐ Yes ☐ No

Chemotherapy _____ ☐ Yes ☐ No

Tumors _____ ☐ Yes ☐ No

Hepatitus A, B,C ☐ A ☐ B ☐ C

Venereal Disease _____ ☐ Yes ☐ No

AIDS/HIVPositive _____ ☐ Yes ☐ No

Cold Sores/Fever Blisters ☐ Yes ☐ No

Blood Transfusion _____ ☐ Yes ☐ No

Hemophilia _____ ☐ Yes ☐ No

Sickle Cell Disease _____ ☐ Yes ☐ No

Bruise Easily _____ ☐ Yes ☐ No

Liver Disease/Yellow Jaundice _____ ☐ Yes ☐ No

Neurological Disorders ☐ Yes ☐ No

Epilepsy or Seizures _____ ☐ Yes ☐ No

Fainting or Dizzy Spells ☐ Yes ☐ No

Nervous/Anxious _____ ☐ Yes ☐ No

Psychiatric/ Psychological Care _____ ☐ Yes ☐ No

9. Have you lost or gained more than 10 pounds in the last year? _____ ☐ Yes ☐ No

10, Do you have or have you had any disease, condition, or problem not listed? _____ ☐ Yes ☐ No

11. Women: Are you pregnant or think you could be pregnant? ☐ Yes _____ Months ☐ No Nursing? ☐ Yes ☐ No

12. Do you use birth control prescriptions? _____ ☐ Yes ☐ No

I understand the above information in necessary to provide me with dental care in a safe and efficient manner. | have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. | will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____