Huei-Ling Chang, D.D.S.
Periodontics & Dental Implants
1286 Kifer Rd., Ste.111, Sunnyvale, CA 94086
Tel: (408)886-8690

Medical-Dental History Form **Date:**_____

The following information will make it possible for us to be more successful and thorough in your treatment. Your answers are for our records only and will be considered confidential.

Last Name:_____ First Name:_____DOB:_____
Age:_____ Male☐ Female☐ Height: _____ Weight:_____ Occupation: _____
Married☐ Single ☐ Spouse's Name _____ Spouse's Phone: _____

Medical History

Are you under the care of a physician? N☐ Y☐ What For? _____
Physician's Name:_____ Phone:_____ Fax:_____
Have you ever had a major illness or operation? N☐ Y☐ What For?_____
Have you ever had any problems with surgery or anesthesia? N☐ Y☐ What?_____

Do you have or have you had any of the following diseases or conditions?

- rheumatic fever or rheumatic heart disease	☐N	☐Y	**- pacemaker**	☐N	☐Y
- congenital heart problem (murmur, prolapsed valve)	☐N	☐Y	**- AIDS/HIV positive**	☐N	☐Y
- heart attack	☐N	☐Y	**- arthritis**	☐N	☐Y
- rheumatism (painful, swollen joints)	☐N	☐Y	**- stroke**	☐N	☐Y
- hepatitis, jaundice or liver disease	☐N	☐Y	**- stomach ulcers**	☐N	☐Y
- high blood pressure	☐N	☐Y	**- kidney problem**	☐N	☐Y
- low blood pressure	☐N	☐Y	**- tuberculosis**	☐N	☐Y
- persistent cough or cough up blood	☐N	☐Y	**- arteriosclerosis**	☐N	☐Y
- chest pain or exertion	☐N	☐Y	**- diabetes**	☐N	☐Y
- psychiatric treatment/counseling	☐N	☐Y	**- bypass surgery**	☐N	☐Y
- shortness of breath	☐N	☐Y	**- anemia**	☐N	☐Y
- swollen ankles	☐N	☐Y	**- glaucoma**	☐N	☐Y
- hives or skin rash	☐N	☐Y	**- thyroid problem**	☐N	☐Y
- fainting spells or seizures (epilepsy)	☐N	☐Y	**- porphyria**	☐N	☐Y
- illness that lasted more than one week	☐N	☐Y	**- allergy**	☐N	☐Y
- sexually transmitted disease	☐N	☐Y	**- other**	☐N	☐Y

Please list any allergies(Latex, Iodine Local Anesthetics), including allergies to Medications:

Are you <u>PRESENTLY TAKING</u> or have you taken any of the following drugs or medications with in the past year?

- antibiotics or sulfa drugs	☐N	☐Y	**- diet-control pills**	☐N	☐Y
- anticoagulants (blood thinners: Coumadin, Plavix, etc.)	☐N	☐Y	**- sleeping pills**	☐N	☐Y
- medicine for high blood pressure	☐N	☐Y	**- vitamins**	☐N	☐Y
- cortisone (steroids)	☐N	☐Y	**- aspirin**	☐N	☐Y
- marijuana or other recreational drugs	☐N	☐Y	**- hormones**	☐N	☐Y
- medicine for diabetes: Insulin, Metformin, etc.	☐N	☐Y	**- digitalis or similar drugs**	☐N	☐Y
- medicine for osteoporosis: Fosamax, Boniva, Zometa, etc.	☐N	☐Y	**- others**	☐N	☐Y

Please list <u>ALL</u> the medications you are currently taking:

Please Continue on Back Page

WOMEN ONLY

Are you pregnant? ☐ N ☐ Y
Are you anticipating becoming pregnant? ☐ N ☐ Y
Are you nursing? ☐ N ☐ Y
Do you take birth control pills or hormones? ☐ N ☐ Y

Do you have any disease, condition or problem **NOT** listed above that you think I should know about? If yes, please explain. N Y

Dental History

Primary Dentist _____ Phone _____
Last Dental Treatment _____ Procedure _____
Give your reason(s) for seeking periodontal/implant treatment
_____
_____
Referred By:_____

Are you experiencing pain from your mouth at this time? N Y_____
Have you ever had periodontal treatment? N Y_____
Are you dissatisfied with the appearance of your teeth? N Y_____
Do you smoke? N Y How much a day?_____
Are you aware of clenching, gritting, or grinding your teeth? N Y_____
Do you brush your teeth at least twice daily? N Y_____
Do you have any dental implants? N Y_____
Have you ever had a frightening experience with dentistry? N Y_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change, I will inform the doctor.

Signature _____ Date _____

Doctor's Comments:
_____
_____

Medical History Update
Any Change? N___ Y_____
Change of Medication N___ Y_____
Patient Signature_____ Date_____ Reviewed By_____

Medical History Update
Any Change? N___ Y_____
Change of Medication N___ Y_____
Patient Signature_____ Date_____ Reviewed By_____

Medical History Update
Any Change? N___ Y_____
Change of Medication N___ Y_____
Patient Signature_____ Date_____ Reviewed By_____

Additional Notes:
_____
_____