WILLIAM J. CHO, D.D.S., M.S.
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Medical / Dental History Forms

Date: _____

Last Name:_____ First Name:_____DOB:_____
Address:_____ City:_____ Zip Code:_____
Phone Number (H/C):_____ (W/C):_____ SS# : _____
Male___ Female___ Married___ Single ___ Email Address_____

Medical History

Do you have a personal physician? _____ Y N
Are you currently under a physicians care? _____Y N
Physician's Name:_____
Phone #:_____Date of last visit:_____

YOUR CURRENT PHYSICAL HEALTH IS:

Good Fair Poor

Do you smoke or use tobacco in any form? Y N If yes, how many per day_____
Are you taking any Bisphosphonates? (For Osteoporosis) Y N
Are you taking any medications? If yes, please list_____
_____
Do you have allergies? If yes, please indicate_____
FOR WOMEN: Are you taking birth control pills? Y N
Are you pregnant? Y N If yes, Weeks#:_____
Are you nursing? Y N

Have you ever had any of the following diseases or medical problems: Please Mark Yes or No.

Y	N	Alcohol/Drug Abuse	Y	N	Herpes/Fever Blisters
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Arthritis	Y	N	HIV +/ AIDS
Y	N	Artificial Joints/Valves	Y	N	Hospitalized for any reason
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Bleeding Problems	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment How long ago?_____
Y	N	Elevated Cholesterol	Y	N	Rheumatic Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Shingles
Y	N	Fainting/Dizzy Spells	Y	N	Sickle Cell Trait/Disease
Y	N	Frequent Headaches/Migraine	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid problems
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia			
Y	N	Hepatitis			

Please list any other medical conditions you have had which are not listed above and explain any (Yes) answers from above.

_____

Please continue on back page

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When was the last time you had a complete dental evaluation?_____

Are you currently in pain?				Y	N
Do you require antibiotics before dental treatment?				Y	N
If yes, which antibiotic:_____					
How often do you brush?	1X/day	2X/day	3X/day		4X/day
Do you floss regularly?				Y	N
Do you feel tooth/teeth sensitivity upon hot and/or cold?				Y	N
Do your gums bleed when brushing?				Y	N
Do you have a bad odor or taste in your mouth?				Y	N
Do you have a hard time chewing?				Y	N
Are you happy with the way your smile looks?				Y	N

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical state. I hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation and/or other medications necessary for dental treatment to be rendered by the dental staff.

Patient's (parent) Signature_____Date:_____

Doctor's Comments/Notes:_____
_____
_____
_____
_____
_____

I verbally reviewed the medical/dental information with the patient (parent) named herein.

Doctor's Signature_____Date:_____

First update
Any Changes:_____
Patient's Signature:_____Date:_____Reviewed By:_____

Second update
Any Changes:_____
Patient's Signature:_____Date:_____Reviewed By:_____