Maxine P. Vu, DDS
FAMILY AND COSMETIC DENTISTRY

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name _____ Phone #: _____

2. Have you been hospitalized (if yes, please explain) Yes No _____

_____

3. Are you under medical treatment now? Yes No If yes, for what?_____

4. **Women**: Are you pregnant? Yes No Are you taking oral contraceptives? Yes No

5. Are you allergic to or have you had any reactions to the following? (please circle if yes)

Local anesthetics Penicillin Sulfa Drugs Barbiturates Sedatives Iodine Latex

Acrylic Codeine Aspirin Other_____

6. Are you taking or have you ever taken any of the following Bisphosphonates/medications (please circle if yes)

Fosamax Actonel Boniva Zometa Reclast

For how long? _____

7. Are you taking any medication including non-prescription medicine? (If yes, please list)

_____

8. Do you have or have you had any of the following?

AIDS or HIV infection	☐Yes ☐No	Frequently tired	☐Yes ☐No	Arthritis	☐Yes ☐No
Alcohol/Drug Abuse	☐Yes ☐No	Glaucoma	☐Yes ☐No	Chest pains	☐Yes ☐No
Anemia	☐Yes ☐No	Heart attack	☐Yes ☐No	Heart disease	☐Yes ☐No
Artificial joints	☐Yes ☐No	Heart murmur	☐Yes ☐No	Pacemaker	☐Yes ☐No
Artificial Heart Valve	☐Yes ☐No	Heart surgery	☐Yes ☐No	Psychiatric disorder	☐Yes ☐No
Asthma	☐Yes ☐No	Hemophilia	☐Yes ☐No	Respiratory illness	☐Yes ☐No
Cancer _____	☐Yes ☐No	Hepatitis	☐Yes ☐No	Stroke	☐Yes ☐No
Diabetes Type 1 or 2	☐Yes ☐No	High blood pressure	☐Yes ☐No	Thyroid problems	☐Yes ☐No
Emphysema	☐Yes ☐No	Kidney disease	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Epilepsy/convulsions	☐Yes ☐No	Liver disease	☐Yes ☐No	Other _____	

PATIENT DENTAL HISTORY

Date of last dental exam: _____ Name of previous dentist & location _____

1. Are your teeth sensitive to hot or cold?	Yes No	6. Do you like your smile?	Yes No
2. Do your gums bleed while brushing?	Yes No	7. Would you like whiter teeth?	Yes No
3. Do you feel pain on any of your teeth?	Yes No	8. Do you smoke or use tobacco?	Yes No
4. Do you clench or grind your teeth?	Yes No	9. Do you have difficulty chewing?	Yes No

5. Have you ever experienced pain in your jaw? Yes No

Authorization and Release

I certify that I have read and answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my medical information to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature: _____ Date: _____