Eric S. Yao, DDS, MAGD
Dedicated Dental Care for Your Family's Good Health

DENTAL & MEDICAL INFORMATION

Name (Please Print)____

Reason for today's visit ____ Date of last dental care_______________________

Former Dentist ____ Date of last dental X-rays_____________________

Former Dentist Phone No.______________________________Address____

Are you currently under the care of a medical doctor? Yes No If yes, please explain___________________________________

Physician (Medical Doctor) Names___________________________ Phone No. _______________________

Address____

Recent surgeries/Hospitalization ____

Prescription Medications:	Over the Counter Medications:
1. ____________________taking for______________________	1.____________________taking for____________________
2.____________________taking for______________________	2.____________________taking for____________________
3.____________________taking for______________________	3.____________________taking for____________________
4.____________________taking for______________________	4.____________________taking for____________________

DENTAL HEALTH HISTORY

COVID19 POSSIBLE SYMPTOMS? PLEASE CHECK ANY THAT APPLY

Fever over 100 F _____ Headache______ Sore throat_______ Dry Cough _______ Chills _______ Sore throat_______

Shortness of breath_______ Difficulty breathing_______ Loss of taste or smell________

Are you in contact with any confirmed COVID-19 positive patients? YES____ No_____

Have you traveled to any regions affected by COVID-19 in the past 14 days? YES______ No_______

PLEASE CHECK ANY THAT APPLY	***YES***	***NO***		***YES***	***NO***
Are you apprehensive about dental treatment?	_____	_____	Chew on one side of your mouth?	_____	_____
Have you had problems with previous dental treatment?	_____	_____	Lip or cheek biting?	_____	_____
If yes, please explain____________________________			History of periodontal problems	_____	_____
Do you smoke cigarettes, pipes or cigars?	_____	_____	Do you gag easily?	_____	_____
Clicking/popping jaw/jaw pain or tiredness?	_____	_____	Do you wear dentures?	_____	_____
Does food catch between your teeth?	_____	_____	Do you clench or grind?	_____	_____
Are you dissatisfied with the appearance of your teeth?	_____	_____	Do you have sensitivity to sours?	_____	_____
Do you have sensitivity to hot/cold foods or liquids?	_____	_____	Do you have sensitivity to sweets?	_____	_____
Do you have slow healing sores in your mouth?	_____	_____	Do you have loose teeth	_____	_____
Does your jaw get stuck so you can't open easily?	_____	_____	Do you have broken fillings	_____	_____

MEDICAL HEALTH HISTORY

PLEASE CHECK ANY THAT APPLY

Asthma/Allergy

_____Asthma _____Hay Fever _____Use Inhaler _____Allergies

Allergic Reactions to

_____Latex or Rubber Dam _____Tetracycline Allergy _____Erythromycin Allergy
_____Penicillin Allergy _____Sulfa Drugs Allergy _____Dental Local Anesthetics (e.g. Novocaine) Allergy
_____Aspirin, Acetaminophen, or Ibuprofen Allergy _____Reaction to Metals
_____Codeine, Demerol, or Other Narcotics _____Barbiturates, Sedatives, or Sleeping Pills

Blood Problems

_____Blood Diseases _____Easy Bruising _____Excessive Bleeding _____High Blood Pressure _____Hemophilia
_____Previous Blood Transfusion _____Low Blood Pressure _____Anemia

MEDICAL HEALTH HISTORY (continued)

PLEASE CHECK ANY THAT APPLY

Heart Problems

_____Chest Pain/Angina _____Artificial Heart Valve
_____Blood Pressure Problem _____ Heart Surgery
_____Congenital Heart Defect _____ Pacemaker _
_____Heart murmur _____ Mitral Valve Prolapse
_____Heart Disease _____ Stroke
_____Heart Attack _____ Shortness of Breath
_____Heart Valve Problem _____Rheumatic Fever
_____Taking Heart Medication _____Others _______________

Women Only

_____ Reached Menopause
_____ Pregnant
If Yes, Due Date_______________
_____ Nursing
_____Taking Contraceptives or Other Hormones

Liver Disease

_____Hepatitis _____Jaundice
_____Liver Disorder

STD

_____Aids _____HIV
_____Herpes or Other STD

Thyroid Disease

_____ Thyroid Problems
_____ Hypothyroid/Hyperthyroid

Joint or Bone Problems

_____Artificial Joints _____Arthritis _____Rheumatism _____Others_________________________________

Other Health Conditions

_____Acid Reflux _____Drug/Alcohol Abuse _____Frequent Mouth Sores _____Nervous Disorders
_____Breathing Difficulty _____Dry Mouth _____Glaucoma _____Persistent Cough
_____Cancer _____Emphysema _____Growths _____Radiation Treatment
_____Colitis _____Epilepsy _____Hospitalized _____Respiratory Problems
_____Diabetes _____Fainting _____Kidney Problems _____Shingles
_____Dizziness _____Frequent Headaches _____Mental Disorders _____Sinus Problems
_____Swollen Glands _____Tuberculosis _____Tumors _____Tobacco Use
_____Ulcers Others____

Have you ever taken in oral form or had I.V. bone density medications (for example Fosamax, Boniva, etc.)
If so, when did you take medication and for how long____
Do you drink alcohol?
If so, how much/how often ____

FOR OFFICE USE ONLY

Initial Blood Pressure:___________________ Pulse:____________________

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for errors or omissions that I may have made in the completion of this form. Furthermore, I grant permission to Eric S. Yao, DDS, PLLC and Staff to perform treatment as deemed professionally necessary. When local anesthetic is administered, I understand that the risks can involve heart palpitation, allergic reaction, hematoma, parasthesia, and drug cross reaction. I further allow the release of my dental records from Dr. Yao to individuals involved in my dental care. I authorize individuals involved in my dental care to release to Dr. Yao any information pertaining to my dental care.

____ ____

Patient / Guardian Signature **Date** **Provider Signature** **Dat**