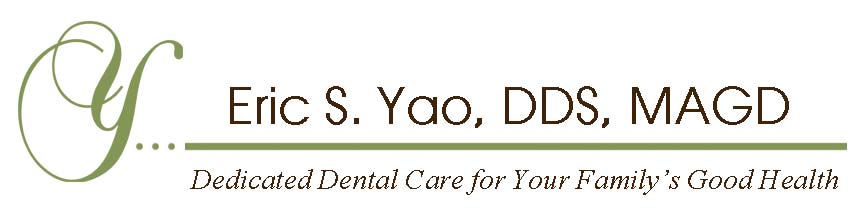
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**DENTAL & MEDICAL INFORMATION**

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**

***PLEASE MARK 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** **Women Only**

\_\_\_\_\_\_Chest Pain/Angina \_\_\_\_\_\_Artificial Heart Valve \_\_\_\_\_\_ Reached Menopause

\_\_\_\_\_\_Blood Pressure Problem \_\_\_\_\_\_ Heart Surgery \_\_\_\_\_\_ Pregnant

\_\_\_\_\_\_Congenital Heart Defect \_\_\_\_\_\_ Pacemaker \_ If Yes, Due Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_Heart murmur \_\_\_\_\_\_ Mitral Valve Prolapse \_\_\_\_\_\_ Nursing

\_\_\_\_\_\_Heart Disease \_\_\_\_\_\_ Stroke \_\_\_\_\_\_Taking Contraceptives or Other Hormones

\_\_\_\_\_\_Heart Attack \_\_\_\_\_\_ Shortness of Breath

\_\_\_\_\_\_Heart Valve Problem \_\_\_\_\_\_Rheumatic Fever

\_\_\_\_\_\_Taking Heart Medication \_\_\_\_\_\_Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Liver Disease**  **STD Thyroid Disease**

\_\_\_\_\_\_Hepatitis \_\_\_\_\_\_Jaundice \_\_\_\_\_\_Aids \_\_\_\_\_\_HIV \_\_\_\_\_\_ Thyroid Problems

\_\_\_\_\_\_Liver Disorder \_\_\_\_\_\_Herpes or Other STD \_\_\_\_\_\_ 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**