COCKEYSVILLE DENTAL

Jocelyn Y. Shin DDS

PATIENT:______________________________ **Date of Birth:**__________

MEDICAL HISTORY

Physician's Name:______________________________

Physician's Address:______________________________

Physician's Phone:__________________ **Date of Last Physical:**__________

PLEASE CHECK IF YOU HAVE OR HAVE EVER HAD:

___ Heart Murmur
___ Heart Disease
___ Heart Attack/Angina
___ High Blood Pressure
___ Artificial Heart Valve
___ Cardiac Pacemaker
___ Artificial Joints
___ Rheumatic Fever
___ Allergies/Asthma
___ Diabetes
___ Stroke
___ Anemia
___ Blood Problem
___ Prolonged Bleeding
___ Liver Disease
___ Kidney Disease
___ Thyroid Disease
___ Epilepsy
___ Hepatitis
___ AIDS
___ Tuberculosis
___ Venereal Disease
___ Herpes
___ Blood Transfusion
___ Steroid Treatment
___ Cancer or Tumor
___ Smoking Habit
___ Alcoholism
___ Drug Habit

Have you ever been tested for AIDS (HIV virus) ? . . . . Yes No
Are you currently being treated by a physician?. . . . . .Yes No
Are you taking drugs, pills, or any medication?. . . . . .Yes No
Are you allergic to any medications (e.g. penicillin, local anesthetic)?. . . . . . . .Yes No
Have you had any major operations or hospitalizations?. . . . . .Yes No
(Women) Are you now pregnant?. . . . . . . .Due Date __________ . . . . .Yes No

DENTAL HISTORY

What prompted you to seek dental care at this time?______________________________

Are you having any discomfort or pain?. . . . . .Yes No
Are any teeth painful to biting, chewing, hot or cold?. . . . . .Yes No
Do you have sore or bleeding gum tissues?. . . . . .Yes No
Are you troubled with bad breath or bad taste?. . . . . .Yes No
Do you suffer frequent sores in your mouth or on your lips?. . . . . .Yes No
Are you aware of grinding or clenching your teeth?. . . . . .Yes No
Do you have clicking-popping noises or pain in or near your ears?. . . . . .Yes No
Do you have frequent headaches, neckaches or backaches?. . . . . .Yes No
Is your bite uncomfortable or do you have trouble chewing?. . . . . .Yes No
Do you have crooked, broken, discolored or missing teeth?. . . . . .Yes No
Do you have old, worn, broken, or discolored fillings needing attention?. . . . . . .Yes No
Are you happy with your smile?. . . . . .Yes No
Are you satisfied with your past dentistry?. . . . . .Yes No
Have you had an unpleasant dental experience?. . . . . .Yes No
Would you like more information on any particular dental treatment?. . . . . . . .Yes No
Have you had dental x-rays taken with-in the past year?. . . . . .Yes No
Do you brush your teeth daily?. . . . . . .Yes No · Do you use any flouride supplements?. . . . . . .Yes No
Do you floss your teeth daily?. . . . . . .Yes No Do you use an Interplak toothbrush?. . . . . . .Yes No
Date of your last dental visit:______________________________

Please add any information that will aid us in planning dental treatment to fit your long term dental health goals.

____

____

____

x______________________________ ______________
Signature of Patient or Parent/Guardian Responsible for Treatment Consent (if a minor) Date

OVER