

So we can ensure we are looking after your needs, please review and complete the following questionnaire:



Patient Health History Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Reason for Today's Visit: _____ Date of Last Dental Visit: _____

All Items on both pages must be marked either Yes or No

Have you ever had any of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS | <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive Thirst | <input type="checkbox"/> Yes <input type="checkbox"/> No Persistent Cough |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatment |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Urination | <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Significant Weight Loss |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Vomiting | <input type="checkbox"/> Yes <input type="checkbox"/> No Respiratory Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joints | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Growths | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatism |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Ringing in Ears |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Head Injuries | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood in Urine or Stools | <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blurred Vision | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bruise Easily | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No STD's |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Canker / Cold Sore | <input type="checkbox"/> Yes <input type="checkbox"/> No Herpes | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No Surgeries |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain (Angina) | <input type="checkbox"/> Yes <input type="checkbox"/> No Hospitalization | <input type="checkbox"/> Yes <input type="checkbox"/> No Swollen Ankles |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Coughing Up Blood | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Pain / Stiffness | <input type="checkbox"/> Yes <input type="checkbox"/> No Transplants |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Swallowing | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Urinating | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Tumors |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness | <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dry Mouth | <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous Disorders | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema / Lung Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No Night Sweats | Other _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis | Other _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive Bleeding | <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker | Other _____ |

Are you allergic to or have you had a reaction to any of the following?

- | | | |
|---|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal | <input type="checkbox"/> Yes <input type="checkbox"/> No Vicodin |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine | <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin | Other _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Erythromycin | <input type="checkbox"/> Yes <input type="checkbox"/> No Tetracycline | Other _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Latex | <input type="checkbox"/> Yes <input type="checkbox"/> No Valium | Other _____ |

Dental Background Information

Have you had or do you have any of the following?

- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bad Breath | <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Chewing | <input type="checkbox"/> Yes <input type="checkbox"/> No Problems Getting Numb |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding Gums | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaw Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No Problems with Dental Work |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Broken Fillings | <input type="checkbox"/> Yes <input type="checkbox"/> No Loose Teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No Sensitivity to Hot / Cold |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Clench / Grind Teeth | <input type="checkbox"/> Yes <input type="checkbox"/> No Old Fillings You Don't Like | <input type="checkbox"/> Yes <input type="checkbox"/> No Yellow Teeth |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Clicking / Popping Jaw | <input type="checkbox"/> Yes <input type="checkbox"/> No Periodontal Problems | Other _____ |

Yes No Do you like your smile? If not, what would you change about it? _____

Yes No Do you brush your teeth? How often? _____

Yes No Do you floss your teeth? How often? _____

Yes No Have you ever considered whitening your teeth?

Yes No Are you interested in straightening your teeth?

Yes No If you're anxious about coming to the dentist, is there something we can do to make your visit more comfortable?

Are you taking or have you taken any of the following in the last three months?

Yes No Alcohol

Yes No Antibiotics

Yes No Aspirin

Yes No Over-the-Counter Medications

Yes No Supplements

Yes No Tobacco

Yes No Weight Loss Medications

Other _____

Other _____

Yes No Have you ever been pre-medicated for dental treatment? If YES, why? _____

Yes No Have you ever taken Fosomax? If YES, when? _____

Yes No Have you ever taken Fen-Phen? If YES, when? _____

Yes No Is there any issue or condition that you would like to discuss with your dentist in private?

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If YES, Please List _____

Women Only – Please complete the following 3 questions.

Yes No Are you or could you be pregnant? If YES, what is your due date? _____

Yes No Are you nursing?

Yes No Are you currently taking birth control pills? If YES, what brand? _____

Yes No Have you ever had any complications following dental treatment?

If yes, please explain _____

Yes No Have you been admitted to a hospital or needed emergency care during the past two years?

If yes, please explain _____

Yes No Are you now under the care of a physician?

If yes, please explain _____

Name of Physician _____ Phone _____

If Kaiser, Location of your Physician _____ Kaiser Number _____

Prior Dentist's Name _____ Phone Number _____ Date of last visit _____

Yes No Do you have any health problems that need further clarification?

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform Dr. Jonathan Vongschanphen, DDS, LVIF at the next appointment without fail.

X _____ Date: _____

Signature of Patient, Parent or Guardian (If under the age of 18 years old)