Yu Oral & Facial Surgery - Yu Oral & Facial Surgery

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Medical History Form

Patient Information

Name	:	Alexa Diana Arellano
Gender	:	Female
DOB	:	4/7/2011
Phone	:	(831) 760-0724

Conditions

ADD or ADHD	Yes	☐	No	☐	Don't Know	☐
AIDS or HIV Infection	Yes	☐	No	☐	Don't Know	☐
Alcohol / Drug Abuse	Yes	☐	No	☐	Don't Know	☐
Angina	Yes	☐	No	☐	Don't Know	☐
Antibiotic Premedication for Dental Work	Yes	☐	No	☐	Don't Know	☐
Arthritis	Yes	☐	No	☐	Don't Know	☐
Artificial (Prosthetic) Heart Valve	Yes	☐	No	☐	Don't Know	☐
Artificial joint(s)	Yes	☐	No	☐	Don't Know	☐
Please specify which joints have been replaced: *						
Asthma	Yes	☐	No	☐	Don't Know	☐
Autism	Yes	☐	No	☐	Don't Know	☐
Autoimmune disease	Yes	☐	No	☐	Don't Know	☐
Describe *						
Bleeding Problems	Yes	☐	No	☐	Don't Know	☐

Blind	Yes	☐	No	☐	Don't Know	☐
Blood Transfusion	Yes	☐	No	☐	Don't Know	☐

What is the date of your last blood transfusion? *

Bronchitis	Yes	☐	No	☐	Don't Know	☐
Cancer	Yes	☐	No	☐	Don't Know	☐

What kind of cancer? *

Cardiovascular disease	Yes	☐	No	☐	Don't Know	☐
Chemo or Radiation Treatment	Yes	☐	No	☐	Don't Know	☐
Chest pain upon exertion	Yes	☐	No	☐	Don't Know	☐
Chronic pain	Yes	☐	No	☐	Don't Know	☐
Cold Sores	Yes	☐	No	☐	Don't Know	☐
Congenital heart disease (CHD)	Yes	☐	No	☐	Don't Know	☐

Please choose the specific congenital heart disease (CHD) that applies to you. *

☐ Unrepaired, cyanotic CHD ☐ Repaired (completely) in last 6 months ☐ Repaired CHD with residual defects

Congestive heart failure	Yes	☐	No	☐	Don't Know	☐
Damaged heart valves	Yes	☐	No	☐	Don't Know	☐
Damaged Valves In Transplanted Heart	Yes	☐	No	☐	Don't Know	☐
Diabetes Type I or II	Yes	☐	No	☐	Don't Know	☐
Eating disorder	Yes	☐	No	☐	Don't Know	☐
Emphysema	Yes	☐	No	☐	Don't Know	☐

		☐		☐		☐
Epilepsy	Yes	☐	No	☐	Don't Know	☐
Excessive urination	Yes	☐	No	☐	Don't Know	☐
Fainting spells or dizzy spells	Yes	☐	No	☐	Don't Know	☐
Frequent Dry Mouth / Sjogren	Yes	☐	No	☐	Don't Know	☐
G.E. Reflux/persistent heartburn	Yes	☐	No	☐	Don't Know	☐
Gastrointestinal disease	Yes	☐	No	☐	Don't Know	☐
Glaucoma	Yes	☐	No	☐	Don't Know	☐
Heart murmur	Yes	☐	No	☐	Don't Know	☐
Hemophilia	Yes	☐	No	☐	Don't Know	☐
Hepatitis, jaundice or liver disease	Yes	☐	No	☐	Don't Know	☐
High Blood Pressure	Yes	☐	No	☐	Don't Know	☐
Kidney problems	Yes	☐	No	☐	Don't Know	☐
Liver or Kidney Disease	Yes	☐	No	☐	Don't Know	☐
Please Describe: *						
Low Blood Pressure	Yes	☐	No	☐	Don't Know	☐
Malnutrition	Yes	☐	No	☐	Don't Know	☐
Mental health disorders	Yes	☐	No	☐	Don't Know	☐
Specify: *						
Neurological disorders	Yes	☐	No	☐	Don't Know	☐

If yes, please specify: *

Night sweats	Yes	☐	No	☐	Don't Know	☐
Osteoporosis	Yes	☐	No	☐	Don't Know	☐

Are you taking medication for your osteoporosis? *

○ YES ○ NO

If yes, please specify the medication you are taking for your osteoporosis:

Other congenital heart defects	Yes	☐	No	☐	Don't Know	☐

Describe *

Pacemaker	Yes	☐	No	☐	Don't Know	☐
Persistent swollen glands	Yes	☐	No	☐	Don't Know	☐

Please Describe: *

Previous Infective Endocarditis	Yes	☐	No	☐	Don't Know	☐
Recurrent Infections	Yes	☐	No	☐	Don't Know	☐

Type of infection: *

Rheumatic Fever	Yes	☐	No	☐	Don't Know	☐
Rheumatic heart disease	Yes	☐	No	☐	Don't Know	☐
Rheumatoid arthritis	Yes	☐	No	☐	Don't Know	☐
Seizures	Yes	☐	No	☐	Don't Know	☐
Severe headaches/ migraines	Yes	☐	No	☐	Don't Know	☐

Severe or rapid weight loss	Yes	☐	No	☐	Don't Know	☐
Sexually transmitted disease	Yes	☐	No	☐	Don't Know	☐
Sinus trouble	Yes	☐	No	☐	Don't Know	☐
Sleep disorder	Yes	☐	No	☐	Don't Know	☐
Snoring	Yes	☐	No	☐	Don't Know	☐
Stroke	Yes	☐	No	☐	Don't Know	☐
Systemic lupus erythematosus	Yes	☐	No	☐	Don't Know	☐
Thyroid problems	Yes	☐	No	☐	Don't Know	☐
Tuberculosis	Yes	☐	No	☐	Don't Know	☐
Ulcers	Yes	☐	No	☐	Don't Know	☐
Wheelchair bound	Yes	☐	No	☐	Don't Know	☐
Other Conditions						

Allergies

Allergy to Amoxicillin	Yes	☐	No	☐	Don't Know	☐
Allergy to Animals	Yes	☐	No	☐	Don't Know	☐
Allergy to Aspirin	Yes	☐	No	☐	Don't Know	☐
Allergy to Barbiturates, Sedatives, or Sleeping pills	Yes	☐	No	☐	Don't Know	☐
Allergy to Codeine / Narcotics	Yes	☐	No	☐	Don't Know	☐
Allergy to Dental Anesthetics	Yes	☐	No	☐	Don't Know	☐
Allergy to Eggs	Yes	☐	No	☐	Don't Know	☐
Allergy to Erythromycin	Yes	☐	No	☐	Don't Know	☐

Allergy to Hay Fever/Seasonal	Yes	☐	No	☐	Don't Know	☐
Allergy to Iodine	Yes	☐	No	☐	Don't Know	☐
Allergy to Keflex	Yes	☐	No	☐	Don't Know	☐
Allergy to Latex / Rubber	Yes	☐	No	☐	Don't Know	☐
Allergy to Metals	Yes	☐	No	☐	Don't Know	☐
Allergy to NSAID	Yes	☐	No	☐	Don't Know	☐
Allergy to Penicillin	Yes	☐	No	☐	Don't Know	☐
Allergy to Sulfa	Yes	☐	No	☐	Don't Know	☐
Allergy to Tetracycline	Yes	☐	No	☐	Don't Know	☐
Other Allergies						

Current Medications

Medication Name	Start Date	End Date

Medical Questionnaire

Is the child being treated by a Physician at this time? *

- ◯ Yes
- ◯ No

If yes, please explain

Is the child taking any medications (prescription or over the counter), vitamins or dietary supplements? *

- ◯ Yes
- ◯ No

If yes, please list

Has the child ever been hospitalized, had surgery or a significant injury? *

- ◯ Yes
- ◯ No

If yes, please explain

Is the child up to date on immunizations against childhood diseases? *

- ◯ Yes
- ◯ No

Has a physician ever said that the child needs pre-med for dental treatment? *

- ◯ Yes
- ◯ No

Primary physician name & phone number *

Date of last physical examination *

Is there anything that we should know about the child's health?

Dental Questionnaire

What is the primary concern about the child's dental health? *

Has the child been examined or treated by another dentist? *

- ◯ Yes
- ◯ No

If yes, date of last dental visit

Has the child ever had orthodontic treatment (braces, spacers, or other appliances)? *

- ◯ Yes
- ◯ No

If yes, please explain

Is there anything else we should know before treating the child?

Does the child have a history of the following?

Cavities / decayed teeth *

- ◯ Yes
- ◯ No

Injury to teeth, mouth or jaws *

- ◯ Yes
- ◯ No

Mouth sores or fever blisters *

- ◯ Yes
- ◯ No

Clenching / grinding teeth *

- ◯ Yes
- ◯ No

Sucking habits after one year of age *

- ◯ Yes
- ◯ No

Excessive gagging *

- ◯ Yes
- ◯ No

Dental Habits

How often does the child brush their teeth per day? *

- ◯ 1
- ◯ 2
- ◯ 3+

Does someone help the child brush? *

- ◯ Yes
- ◯ No

How often does the child floss their teeth? *

- ○ Daily
- ○ Weekly
- ○ Monthly
- ○ Does not floss

Does someone help the child floss?

- ○ Yes
- ○ No

Please check all sources of fluoride the child receives

Drinking water

- ☐ Yes

Toothpaste

- ☐ Yes

Fluoride Treatment in the dental office

- ☐ Yes

Prescription rinse/gel

- ☐ Yes

Prescription drops/tablets/vitamins

- ☐ Yes

By signing below, I certify that all the above information is true to the best of my knowledge. I understand the importance of this information and that the practice will rely on this information for the treatment. I will not hold the practice or any member / staff of the practice, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient or Responsible Party

Signed on