

Health Information & History



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Patient Name _____
First Last M.I.

Birthdate _____

Medical History

1. Are you under a Doctor's care at this time? Yes ___ No ___ If yes, What's Dr. Name _____ Dr. Ph# _____
Please specify: _____

2. Are you currently taking any medication? Yes ___ No ___ If yes, please specify: _____

Do you have, or have you had, any of the following? Please mark any that apply.

Allergy Problems		Yes	No	Heart Problems		Yes	No	Others		Yes	No	Doctor's Comments
1. Hay fever.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	38. AIDS/ HIV positive.....	<input type="checkbox"/>	<input type="checkbox"/>	39. History of alcohol or drug abuse..	<input type="checkbox"/>	<input type="checkbox"/>	
2. Sinus problems.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	40. Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how much?			
3. Skin rashes.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Blood pressure problem.....	<input type="checkbox"/>	<input type="checkbox"/>	41. Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	If so, how much?			
4. Taking allergy medication.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	42. Do you wear contact lenses.....	<input type="checkbox"/>	<input type="checkbox"/>				
5. Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Heart valve problem.....	<input type="checkbox"/>	<input type="checkbox"/>	43. Fainting Spells.....	<input type="checkbox"/>	<input type="checkbox"/>				
6. Allergy to medications.....	<input type="checkbox"/>	<input type="checkbox"/>	24. Taking heart medication.....	<input type="checkbox"/>	<input type="checkbox"/>	44. Frequent/severe headaches.....	<input type="checkbox"/>	<input type="checkbox"/>				
Blood Problems		Yes	No	25. Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	45. Herpes or other STD.....	<input type="checkbox"/>	<input type="checkbox"/>			
7. Easy bruising.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Pacemaker.....	<input type="checkbox"/>	<input type="checkbox"/>	46. History of head injury.....	<input type="checkbox"/>	<input type="checkbox"/>				
8. Frequent nosebleeds.....	<input type="checkbox"/>	<input type="checkbox"/>	27. Artificial heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>	47. Any neurological disease.....	<input type="checkbox"/>	<input type="checkbox"/>				
9. Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Heart Surgery.....	<input type="checkbox"/>	<input type="checkbox"/>	48. Thyroid problems.....	<input type="checkbox"/>	<input type="checkbox"/>				
10. Blood disease (anemia).....	<input type="checkbox"/>	<input type="checkbox"/>	29. Heart Attack.....	<input type="checkbox"/>	<input type="checkbox"/>	49. Persistent cough/Swollen glands..	<input type="checkbox"/>	<input type="checkbox"/>				
11. Blood transfusion before.....	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Problems		Yes	No	50. Tuberculosis or other respiratory..	<input type="checkbox"/>	<input type="checkbox"/>			
12. Blood thinning medication.....	<input type="checkbox"/>	<input type="checkbox"/>	30. Ulcers.....	<input type="checkbox"/>	<input type="checkbox"/>	51. Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>				
Bone or Joint Problems		Yes	No	31. Weight gain or loss.....	<input type="checkbox"/>	<input type="checkbox"/>	52. Phen-fen.....	<input type="checkbox"/>	<input type="checkbox"/>			
13. Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	32. Special diet.....	<input type="checkbox"/>	<input type="checkbox"/>	53. Psychiatric treatment.....	<input type="checkbox"/>	<input type="checkbox"/>				
14. Back or neck pain.....	<input type="checkbox"/>	<input type="checkbox"/>	33. Constipation/Diarrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	54. Chemo/Rad therapy.....	<input type="checkbox"/>	<input type="checkbox"/>				
15. Joint replacement.....	<input type="checkbox"/>	<input type="checkbox"/>	34. Kidney or bladder problems.....	<input type="checkbox"/>	<input type="checkbox"/>	55. Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>				
if so, when?			Liver Problems		Yes	No	56. Cancer/Tumor.....	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes		Yes	No	35. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>						
16. Urinate 6 times or + a day....	<input type="checkbox"/>	<input type="checkbox"/>	36. Liver Problems.....	<input type="checkbox"/>	<input type="checkbox"/>							
17. Thirsty or mouth is dry often..	<input type="checkbox"/>	<input type="checkbox"/>	37. Yellow Jaundice.....	<input type="checkbox"/>	<input type="checkbox"/>							
18. Family history of diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>										

Are there any other health problems of which we should be advised? Please specify: _____

Dental History

1. What is the purpose of today's dental appointment? _____

2. When did you last visit a dentist? _____

3. Do you have toothache now? Yes ___ No ___

4. Former dentist _____ phone # (if known) _____

5. Have you had any problems with past dental treatment? Yes ___ No ___

If yes, please specify: _____

6. Date of last X-rays? _____ 7. Date of last full-mouth X-rays? _____

8. How often do you brush? _____ 9. How often do you floss? _____

Yes	No	Please mark Yes or No	Dr. Comments
<input type="checkbox"/>	<input type="checkbox"/>	9. Do your gums bleed easily, or feel tender or irritated?	
<input type="checkbox"/>	<input type="checkbox"/>	10. Do you wear dentures?	
<input type="checkbox"/>	<input type="checkbox"/>	11. Do you gag easily?	
<input type="checkbox"/>	<input type="checkbox"/>	12. Do you feel you have bad breath?	
<input type="checkbox"/>	<input type="checkbox"/>	13. Would you like your teeth whiter or straighter?	
<input type="checkbox"/>	<input type="checkbox"/>	14. Do you clench/ grind your teeth?	
<input type="checkbox"/>	<input type="checkbox"/>	15. Does food catch between your teeth?	
<input type="checkbox"/>	<input type="checkbox"/>	16. Do you take fluoride supplements?	
<input type="checkbox"/>	<input type="checkbox"/>	17. Have you had trauma to the jaw?	
<input type="checkbox"/>	<input type="checkbox"/>	18. Do you have loose, tipped, or shifting teeth?	
<input type="checkbox"/>	<input type="checkbox"/>	19. Do you have problems with teeth / fillings breaking?	
<input type="checkbox"/>	<input type="checkbox"/>	20. Do you had any periodontal (gum) treatment?	
<input type="checkbox"/>	<input type="checkbox"/>	21. Are you apprehensive about dental treatment?	
<input type="checkbox"/>	<input type="checkbox"/>	22. Are your teeth sensitive to hot, cold, sweets, pressure? (if so, please circle)	
<input type="checkbox"/>	<input type="checkbox"/>	23. Do you have a temporomandibular disorder (TMD, TMJ)?	
<input type="checkbox"/>	<input type="checkbox"/>	24. Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain or locking open?	

Are you allergic, or have you reacted adversely, to any of the following? Please mark any that apply.

- | | |
|-------------------------|-------------------------------|
| ___ Aspirin | ___ Local anesthetics |
| ___ Acetaminophen | ___ Nitrous Oxide |
| ___ Barbiturates | ___ Penicillin |
| ___ Codeine | ___ Percodan |
| ___ Darvon | ___ Sulfa drugs |
| ___ Demerol | ___ Sedatives (sleeping pill) |
| ___ Erythromycin | ___ Tetracycline |
| ___ Ibuprofen | ___ Tranquilizers |
| ___ Latex or rubber dam | ___ Valium |

Any other drugs or medicine? Please list _____

(For Women)

- Are you taking contraceptives? Yes No
- Are you taking hormones? Yes No
- Are you pregnant? Yes No If so, # of month? _____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of X-rays and oral examination.

Signature of responsible party or patient _____ Date _____