Phuoc Tran, DDS
Alexandra Shehata, DDS
Arlene Esche, DDS
Pedodontist

Medical History

Are you currently under the care of a physician?	□ **Yes** □ **No** If yes:	
Do you have a preferred pharmacy? Location/Phone	□ **Yes** □ **No** If yes:	
Have you ever been to the hospital/had surgery since your last visit?	□ **Yes** □ **No** If yes:	
Are you taking any prescribed or over the counter medications?	□ **Yes** □ **No** If yes:	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Infusion?	□ **Yes** □ **No** If yes:	
Any allergies to medications? Latex? Environmental? Food allergies?	□ **Yes** □ **No** If yes:	
Do you use tobacco or vape? How often?	□ **Yes** □ **No** If yes:	
Do you use controlled substances? Recreational use or prescription?	□ **Yes** □ **No** If yes:	

Do you have, or have you had any of the following?

AID/HIV Positive	□ Yes □ No	Alzheimer's Disease	□ Yes □ No	Arthritis/Gout	□ Yes □ No
Artificial Joint	□ Yes □ No	Asthma	□ Yes □ No	Autism	□ Yes □ No
Blood Transfusion	□ Yes □ No	Cancer	□ Yes □ No	Chemotherapy	□ Yes □ No
Diabetes	□ Yes □ No	Downs Syndrome	□ Yes □ No	Drug Addiction	□ Yes □ No
Excessive Bleeding	□ Yes □ No	Fainting Spells/Dizziness	□ Yes □ No	Frequent Headaches	□ Yes □ No
Heart Disease	□ Yes □ No	Heart Pacemaker	□ Yes □ No	Hepatitis A, B or C	□ Yes □ No
High Cholesterol	□ Yes □ No	Hypoglycemia	□ Yes □ No	Kidney Problems	□ Yes □ No
Low Blood Pressure	□ Yes □ No	Lung Disease	□ Yes □ No	Nursing	□ Yes □ No
Pain in Jaw Joints	□ Yes □ No	Pregnant/Trying	□ Yes □ No	Psychiatric Care	□ Yes □ No
Rheumatism	□ Yes □ No	Rheumatism Fever	□ Yes □ No	Sensory Disorder	□ Yes □ No
Sinus Trouble	□ Yes □ No	Sleep Apnea	□ Yes □ No	Stomach/Intestinal Disease	□ Yes □ No
Thyroid Disease	□ Yes □ No	Tonsillitis	□ Yes □ No	Tuberculosis	□ Yes □ No
Venereal Disease	□ Yes □ No	Artificial Heart valve	□ Yes □ No	Blood Disease	□ Yes □ No
Cold Sores/ Fever Blisters	□ Yes □ No	Epilepsy/Seizures	□ Yes □ No	Heart Attack/Failure	□ Yes □ No
High Blood Pressure	□ Yes □ No	Liver Disease	□ Yes □ No	Osteoporosis	□ Yes □ No
Radiation Treatments	□ Yes □ No	Shingles	□ Yes □ No	Stroke	□ Yes □ No
Ulcers	□ Yes □ No				

Do you have or have you had any of the following?

Sensitivity to hot/cold/sweet	□ Yes □ No	Bleeding/Swollen/Tender Gums	□ Yes □ No	Previous Ortho Treatment	□ Yes □ No
Visit to a Periodontist	□ Yes □ No	Wear a Removable Appliance	□ Yes □ No	Mouth Breathing	□ Yes □ No
Oral Habits i.e. chew ice	□ Yes □ No	Headaches/Jaw Pain	□ Yes □ No	Snoring	□ Yes □ No

What are the most important factors you desire from your dental office?

Signature: _____ Date: _____