Chart # _____

Smile LA Dental

2706 W Jefferson Blvd, Los Angeles, CA 90018

Today's Date: _____

Patient Information

Name:

First _____ MI____ Last_____

Date Of Birth _____ Sex: M/F

Phone: Home_____ Mobile _____

Work _____

Email:_____

Address: _____

City:_____ State: _____ Zip Code:_____

Occupation:_____

Driver's license: _____

Insurance: □ None □ Medical □ Other _____

Id Number:_____

In Case of Emergency contact: _____

Relationship to patient: _____

Phone: Home_____ Mobile _____

Work _____

I. Circle appropriate answer

1.- Yes/No Is your general health good?
If NO, explain:_____

2.- Yes/No Has there been a change in your health within the last year?
If YES, explain:_____

3.- Yes/No Have you gone to the hospital or emergency room or had a serious illness in the last three years?
If YES, explain:_____

4.- Yes/No Are you being treated by a physician now?
If YES, explain:_____

Physician's Name: _____ Phone Number: _____

5.- Yes/No Have you had problems with prior dental treatment?
If YES, explain:_____

Date of last dental exam: _____ Name of last treating dentist:_____

6.- Yes/No Are you in pain now?
If YES, explain:_____

II. Have you experienced any of the following? (Please circle Yes or No for each)

Yes/No	Chest pain (angina)	Yes / No	Blood in stools	Yes / No	Frequent vomiting
Yes/No	Fainting spells	Yes/No	Diarrhea or constipation	Yes/No	Jaundice
Yes/No	Recent significant weight loss	Yes/No	Frequent urination	Yes/No	Dry mouth
Yes/No	Fever	Yes/No	Difficulty urinating	Yes/No	Excessive thirst
Yes/No	Night sweats	Yes/No	Ringing in ears	Yes/No	Difficulty swallowing
Yes/No	Persistent cough	Yes/No	Headaches	Yes/No	Swollen ankles
Yes/No	Coughing up blood	Yes/No	Dizziness	Yes/No	Joint pain or stiffness
Yes/No	Bleeding problems	Yes/No	Blurred vision	Yes/No	Shortness of breath
Yes/No	Blood in urine	Yes/No	Bruise easily	Yes/No	Sinus problems

III. Have you had or do you have any of the following? (Please circle Yes or No for each)

Yes/No	Heart disease	Yes/No	Cosmetic surgery	Yes/No	Eating disorders
Yes/No	Family history of heart disease	Yes/No	Surgeries	Yes/No	Osteoporosis
Yes/No	Heart attack	Yes/No	Hospitalization	Yes/No	Thyroid disease
Yes/No	Artificial joint	Yes/No	Diabetes	Yes/No	Asthma
Yes/No	Stomach problems or ulcers	Yes/No	Family history of diabetes	Yes/No	Hepatitis
Yes/No	Heart defects	Yes/No	Tumors or cancer	Yes/No	Sexual transmitted disease
Yes/No	Heart murmurs	Yes/No	Chemotherapy	Yes/No	Herpes
Yes/No	Rheumatic fever	Yes/No	Radiation	Yes/No	Canker or cold sores
Yes/No	Skin disease	Yes/No	Arthritis, rheumatism	Yes/No	Anemia
Yes/No	Hardening of arteries	Yes/No	Emphysema or other lung disease	Yes/No	Liver disease
Yes/No	High blood pressure	Yes/No	Kidney or bladder disease	Yes/No	Eye disease
Yes/No	Seizures	Yes/No	Stroke	Yes/No	Transplants
Yes/No	Tuberculosis	Yes/No	AIDS/HIV	Yes/No	Depression

IV. Are you allergic to any of the following?

Yes/No	Aspirin	Yes/No	Valium	Yes/No	Tetracycline
Yes/No	Darvon	Yes/No	Codeine	Yes/No	Latex
Yes/No	Demerol	Yes/No	Penicillin	Yes/No	Erythromycin
Yes/No	Tetracycline	Yes/No	Vicodin	Yes/No	Percodan
Yes/No	Nitrous oxide	Yes/No	Metal	Yes/No	Local anesthetic (Novocain or Xylocaine)

Others:_____

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

Yes/No	*Recreational drugs*	Yes/No	*Tobacco in any form*	Yes/No	*Antibiotics*
Yes/No	*Over-the-counter medicines*	Yes/No	*Alcohol*	Yes/No	*Supplements*
Yes/No	*Weight loss medications*	Yes/No	*Bisphosphonate (Fosamax)*	Yes/No	*Aspirin*
Yes/No	*Cortico – Steroids*				

Please list all medications you are currently taking:_____

VI. Women only

Yes/No Are you or could you be pregnant? If YES, what month? _____
Yes/No Are you nursing?
Yes/No Are you taking birth control pills?

VII. All Patients

Yes/No Do you have or had any other diseases or medical problems NOT listed on this form?
If YES, explain _____

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

Yes/No Have you taken Fen-Phen?
If YES when_____

Yes/No Is there any other condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.
I certify that I have read and understand this form. 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. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____ _____
Signature of Patient (Parent or Guardian) Name Date

_____ _____
Signature of Dentist Date

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Change to Health History	Dentist Initials