Medical History Form:

SAC DENTIST

Name: ____________________

Date of Birth: _______________

(In order to provide greater safety to you and our staff in treating your dental needs, the information provided needs to be accurate and complete. If there is anything else that is unclear to you, please feel free to ask us. Thank you for choosing Laurel Hills Dental!)

Prescription medicines you are currently taking: (Please provide us a copy of the list if it does not fit in this box.)	**Allergies or reactions to medications or anesthetics:**

1. Physician: ____________________ Facility (e.g. Kaiser, Sutter): _________________ Contact #: ______________
2. Do you need to take prophylactic antibiotics before any dental treatment? Yes No

   If yes, what is the drug name: ________________________________

3. Have you had or do you currently have any of the following medical conditions? Please mark Yes or No.

Yes	No		Yes	No		Yes	No	
		Heart Attack / Surgery			Chronic cough			Bruise Easily
		Chest Pain			Tuberculosis			Liver Disease
		Congenital Heart Disease			Asthma			Jaundice
		Heart Murmur			Radiation therapy			Neurological disorder
		High Blood Pressure			Latex sensitivity/Allergy			Psychological care
		Mitral Valve Prolapse			Sinus Problems			Kidney Problems
		Artificial Heart Valve			Chemotherapy			Stroke
		Heart Pacemaker			Cancer. Type:________			Artificial Joints
		Rheumatic Fever			Hepatitis. Type: ________			Epilepsy/Seizures
		Arthritis / Rheumatism			STD			Tumors
		Fainitng/Dizziness			AIDS			Swollen Ankles
		Diabetes. Type: ______			HIV positive			Osteoporosis/ Taking Bisphosonate drugs
		Thyroid problems			Cold Sores			Taking weight loss meds (Fen-Phen & Redux)
		Emphysema			Hemophilia			

4. Have you had or do you currently have any of the following dental conditions?

Yes	No		Yes	No		Yes	No	
		Gum/Periodontal Treatment			Difficulty Sleeping/Snoring			Neck Pain / Headaches
		Braces/Orthodontic Treatment			Clicking/Popping/Grinding of jaw			Difficulty in chewing
		Trauma to head/teeth						
		Oral Surgery						

6. For Women: Are you pregnant? Yes No Are you nursing? Yes No

Please use this space to cover anything else you want us to know.

I have answered all questions fully and to the best of my knowledge. If other health issues arise in the future, I understand that it is my responsibility to inform Dr. Hinh and the staff of these changes.

Patient Signature: ___________________ Guardian Signature (for patients below 18 y.o.): ___________________

Date: ________________