Seattle Choice Dental
Dr. Cho, DDS
9714 3rd Ave., Suite 200
Seattle, WA 98115
O (206)523-7600 F (206)524-2711

HEALTH HISTORY

Although our dental team primarily treats the area in and around your mouth, it is important for us to know about your overall health. Medical conditions or medications that you may be taking could have an important relationship with the dentistry you receive. Thank you for answering the following questions. All information is kept strictly confidential.

DENTAL HEALTH HISTORY

Name_____

Previous dentist_____ City_____

How long _____ Date of last checkup and cleaning_____

Reason for today's visit _____

How often do you brush? _____ Floss? _____ See a dentist? _____

What, if anything, would you change about your teeth? _____

Do you wear a nightguard? _____ Are you a habitual gum or ice chewer? _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Anxiety about dental treatment	O	O	Orofacial (mouth/face) pain	O	O
Problems with past dental treatment	O	O	Head/Neck injury or radiation	O	O
Wear dentures	O	O	Lip/mouth sores that are slow to heal	O	O
Difficulty chewing your food	O	O	Problems after a tooth extraction	O	O
Bleeding gums	O	O	Periodontal Disease	O	O
Sore or sensitive teeth	O	O	Deep cleaning (root planing)	O	O
Grind or clench your teeth	O	O	Periodontal Treatment (gum grafts)	O	O

	YES	NO		YES	NO
Difficulty opening	O	O	Oral Surgery	O	O
Temporomandibular disorder (TMD)	O	O	Orthodontic Treatment	O	O

Seattle Choice Dental
Dr. Cho, DDS
9714 3rd Ave., Suite 200
Seattle, WA 98115
O (206)523-7600 F (206)524-2711

MEDICAL HISTORY

Physician's name _____ Type _____ How long? ____

Office Address _____ Phone _____

Please list all medications that you currently take _____

_____

_____

Do you require premedication (antibiotics) before dental treatment? _____

If yes, what? _____

Do you use tobacco or smoke?_____ If so, what type_____

How much? _____ How long? _____

Do you use cannabis?___ Yes ___ No How often? _____

Do you consume alcohol? _____ If so, how much?_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Hospitalization for illness or surgery	O	O	Blood transfusion	O	O
Heart trouble/disease	O	O	Ulcers	O	O
Heart attack or failure	O	O	Significant weight gain or loss	O	O
Chest pains	O	O	Special diet	O	O
Shortness of breath	O	O	Intestinal problems	O	O
Heart valve problems/artificial valve	O	O	Kidney disease or bladder problems	O	O
Heart murmur	O	O	Arthritis	O	O
Rheumatic fever	O	O	Back or neck pain	O	O
Pacemaker	O	O	Joint replacement/pin placement	O	O
High blood pressure	O	O	Fainting spells, seizures, or epilepsy	O	O
Low blood pressure	O	O	Frequent or severe headaches	O	O
Stroke	O	O	Thyroid or parathyroid disorders	O	O
Easy bruising	O	O	Persistent cough or swollen glands	O	O

Abnormal bleeding	O	O	Hepatitis (indicate type)	O	O
Anemia or other blood disorders	O	O	Jaundice	O	O
Liver disease	O	O	Sinus problems	O	O
Diabetes	O	O	Emphysema	O	O
Frequent urination	O	O	Emotional problems or tension	O	O
Frequent thirst or dry mouth	O	O	Psychiatric treatment	O	O
Taken Phen-Fen	O	O	History of alcohol or drug abuse	O	O
Tuberculosis	O	O	History of head injury	O	O

Scarlet Fever	O	O	Cancer or Tumor	O	O
Glaucoma	O	O	Radiation treatment	O	O
Wear contact lenses	O	O	Prostate disorders (if male)	O	O
Asthma	O	O	HIV positive	O	O
Hives, skin rash, hay fever	O	O	AIDS	O	O

ARE YOU ALLERGIC OR REACTED ADVERSELY TO ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Local Anesthetics ("novocaine")	O	O	Metal	O	O
Penicillin or other antibiotics	O	O	Latex	O	O
Sulfa drugs	O	O	Aspirin	O	O
Tetracycline	O	O	Acetaminophen	O	O
Sedatives or sleeping pills	O	O	Ibuprofen	O	O
Codeine or other narcotic	O	O	Any other medication	O	O

DURING THE PAST 12 MONTHS, HAVE YOU TAKEN ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Antibiotics or sulfa drugs	O	O	Anticoagulants (e.g., coumadin)	O	O
High Blood Pressure Medication	O	O	Tranquilizers	O	O
Insulin, Orinase, or similar	O	O	Aspirin	O	O
Digitalis or other heart medication	O	O	Nitroglycerin	O	O

	YES	NO		YES	NO
Cortisone or other steroids	O	O	Natural remedies	O	O
Vitamin Supplements	O	O	Nonprescription drugs	O	O

WOMEN:

	YES	NO		YES	NO
Are you pregnant	O	O	Taking oral contraceptives	O	O
Nursing	O	O	Reached Menopause	O	O

Do you have any disease, condition, or problem not listed previously that we should know about? If so, please describe in detail _____

_____

_____

To the best of my knowledge, the questions on this form have been adequately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental staff of any changes in my health history.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

_____ DATE _____

DENTAL STAFF INITIALS _____ DATE _____

DENTIST'S INITIALS _____ DATE _____