NORTH EAST MEDICAL SERVICES
東 北 醫 療 中 心

NEMS MRN:

NAME:

Date of Birth:

DENTAL HISTORY

Do you have or have you had any problem(s) with dental treatment in the past? ☐ Yes ☐ No
Do you need pre-medicated with antibiotic before dental appointment in the past? ☐ Yes ☐ No
Has there been any change in your general health in the last two years? ☐ Yes ☐ No
Have you taken any medication for osteoporosis? If yes, for how long?_____ ☐ Yes ☐ No
Are you now under the care of a physician? ☐ Yes ☐ No
If yes, physician's name: _____

Any serious illness, operations, or hospitalizations in the last 5 years? ☐ Yes ☐ No
If yes, please describe: _____

Approximate date of last physical exam? ____/____/____ Females: are you pregnant? ☐ Yes ☐ No
If yes, how many months? _____

Are you taking any of the following

Antibiotics	☐ Yes ☐ No	Insulin	☐ Yes ☐ No
Anticoagulants (blood thinners)	☐ Yes ☐ No	Blood pressure medication	☐ Yes ☐ No
Cortisone (steroids)	☐ Yes ☐ No	Heart drugs	☐ Yes ☐ No

Other medications _____

Have you had a bad reaction to the following:

Local anesthetics (novocaine, lidocaine)	☐ Yes ☐ No	Aspirin or codeine	☐ Yes ☐ No
Penicillin or other antibiotics	☐ Yes ☐ No	Latex allergy	☐ Yes ☐ No

Other medication _____

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

	Yes	No		Yes	No
Abnormal bleeding after surgery	☐	☐	Artificial joint/implant	☐	☐
Chronic sinus problems	☐	☐	Asthma	☐	☐
Congenital heart disease	☐	☐	Breathing issues	☐	☐
Developmental/intellectual disability	☐	☐	Chest pain/angina	☐	☐
Diabetes or high blood sugar	☐	☐	Hemophilia or anemia	☐	☐
Frequent severe headaches	☐	☐	Hypertension	☐	☐
Heart attack/heart surgery	☐	☐	High cholesterol	☐	☐
Hepatitis, jaundice, liver disease	☐	☐	HIV/AIDS	☐	☐
Problems with opening mouth wide	☐	☐	Kidney disease	☐	☐
Radiation treatment for tumor	☐	☐	Previous cancer	☐	☐
Rheumatic fever or heart murmur	☐	☐	Psychiatric problems	☐	☐
Seizures, epilepsy, fainting	☐	☐	Recreational drugs	☐	☐
Thyroid disease or goiter	☐	☐	Stomach ulcers	☐	☐
Tuberculosis, emphysema, bronchitis	☐	☐	Stroke	☐	☐
			Use tobacco products	☐	☐

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Other health problems or conditions _____

I have read and answered the above questions to the best of my knowledge. I understand this information is necessary to provide me with dental care in a safe and efficient manner. I will notify this clinic of any future changes in the health or medications taken by me.

Signature of Patient or Legal Representative*	Date | Time
Name of Legal Representative	Relationship of Legal Representative
Signature of Witness (Required if patient is unable to sign)	Date | Time