Thu Linh Nguyen, D.D.S., Inc.
110 South Abel Street | Milpitas, CA 95035 | (408) 934-9646
linhnguyendds@yahoo.com | www.linhnguyendds.com

MEDICAL HISTORY

Physician_____ Office Phone_____ Date of last exam_____

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

Please mark the box next to any of the following condition(s) that may apply to you.

Chest Pain	☐	Sinus difficulty	☐
Angina Pectoris	☐	Difficult Breathing/ Asthma	☐
Liver disease	☐	Kidney Trouble	☐
High Blood Pressure	☐	Hepatitis	☐
Anemia	☐	Venereal Diseases	☐
Blood Transfusion	☐	Epilepsy or Seizures	☐
Shortness of Breath	☐	Thyroid Disease	☐
Ulcers, Stroke	☐	Radiation Therapy	☐
Drug Addiction	☐	Chemotherapy	☐
Cold Sores	☐	Cancer (Type)	☐
Herpes	☐	Arthritis/Rheumatism	☐
Hay fever	☐	Prosthetic Heart Valve	☐
Diabetes	☐	Heart Pacemaker	☐
Tuberculosis (TB)	☐	Surgeries	☐
Heart Surgery	☐	AIDS or ARC	☐
Heart Failure	☐	Jaundice, Bruise easily	☐
Heart Problems	☐	Hives or skin rash	☐
Prolonged Bleeding	☐	High Cholesterol	☐

Antibiotic pre-medication may be required prior to your appointment if you have any of the following:

- Heart Murmur ☐
- Rheumatic Fever ☐
- Artificial joints ☐
- Any type of transplant ☐
- Mitral Valve Prolapse ☐
- Steroid Treatment ☐
- Any type of implant ☐
- Congenital Heart Problems ☐

Allergies

- Aspirin ☐
- Barbiturates ☐
- Codeine ☐
- Iodine ☐
- Latex ☐
- Local Anesthetic ☐
- Penicillin ☐
- Sulfa ☐
- Metals ☐
- Other... ☐

Medications

Are you currently taking any of the following drugs?

- Fosamax(Alendronate) ☐
- Zometa or Evista, ☐
- Fen- Phen/Redux, ☐
- Daily Aspirin or Omega-3 (Fish Oil) ☐
- Coumadin ☐

Please list any medications you are currently taking _____

_____

WOMEN: Are you pregnant now? ☐ If yes, what is your due date?_____

- Are you currently breast feeding? ☐
- Are you taking oral contraceptive? ☐

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DENTAL HISTORY

Previous dentist & location_____ Date of last exam_____

Please mark the box next to any of the following condition(s) that may apply to you.

Do your gums bleed while brushing or flossing? ☐

Are your teeth sensitive to hot or cold? ☐

Are your teeth sensitive to sweet or sour? ☐

Do you feel pain to any of your teeth? ☐

Do you have any sores or lumps in or near your mouth? ☐

Have you had any head, neck, or jaw injuries? ☐

Have you ever experienced any of the following:

Jaw clicking ☐

Pain (jaw, joint, ear, side of face) ☐

Difficulty opening or closing jaw ☐

Difficulty chewing ☐

Do you have frequent headaches? ☐

Do you clench or grind your teeth? ☐

Do you bite your lips or cheeks frequently? ☐

Have you had difficult extractions in the past? ☐

Have you had prolonged bleeding after extractions? ☐

Have you had any orthodontic treatment? ☐

Do you wear dentures or partials? ☐

If yes, date of placement:_____

Have you ever received oral hygiene instructions regarding the care of your teeth and/or gums? ☐

Does food collect between your teeth? ☐

Do you have problem with bad breath? (Halitosis) ☐

Do you now have bleeding gums or any other gum condition? ☐

Do you drink tea/ coffee daily? ☐

Do you smoke/ drink alcohol? ☐

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AUHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and /or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise pay able to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ Date_____

Signature of patient or guardian Print name