FEI HWANG, D.D.S. INC. Dental Care You Can Smile About

Medical History

Do you have a personal physician? · Yes · No
Physician's Name: _____ Physician's Phone:_____
Date of last visit:_____ Your current physical health is: · Good · Fair · Poor
Are you currently under the care of a physician? · Yes · No
Please explain: _____
Do you use tobacco in any form? ·Yes · No Have you had any metal rods, pins or implants placed? · Yes · No
Are you taking bisphosphonates (fosamax, actonel, boniva, reclast, zometa, etc.) for osteoporosis? · Yes · No
Are you taking any medications? · Yes · No
Please list each of medication: _____
Have you ever had any surgical procedures? · Yes · No
Please list each one: _____

Conditions	Conditions	Conditions
Yes No Abnormal Bleeding	Yes No Glaucoma	Yes No Sickle Cell Disease
Yes No Alcohol Abuse	Yes No HIV & AIDS	Yes No Sinus Problems
Yes No Allergies	Yes No Heart Attack	Yes No Stroke
Yes No Anemia	Yes No Heart Murmur	Yes No Thyroid Problems
Yes No Angina Pectoris	Yes No Heart Surgery	Yes No Ulcers
Yes No Arthritis	Yes No Hemophilia	**Allergies**
Yes No Artificial Heart Valve	Yes No Hepatitis A	Yes No Aspirin
Yes No Asthma	Yes No Hepatitis B	Yes No Codeine
Yes No Blood Transfusion	Yes No Hepatitis C	Yes No Dental Anesthetics
Yes No Cancer	Yes No High Blood Pressure	Yes No Erythromycin
Yes No Chemotherapy	Yes No Joint Replacement	Yes No Jewelry
Yes No Colitis	Yes No Kidney Problem	Yes No Latex
Yes No Congenital Heart Defect	Yes No Liver Disease	Yes No Metals
Yes No Diabetes	Yes No Low Blood Pressure	Yes No Penicillin
Yes No Difficulty Breathing	Yes No Mitral Valve Prolapse	Yes No Tetracycline
Yes No Drug Abuse	Yes No Pace Maker	**Yes No If Female**
Yes No Emphysema	Yes No Psychiatric Problems	Yes No Are you taking Birth
Yes No Epilepsy	Yes No Radiation Therapy	Control Pills?
Yes No Facial Surgery	Yes No Rheumatic Fever	Yes No Are you pregnant?
Yes No Fainting Spells	Yes No Seizures	If so, # of Weeks____
Yes No Fever Blisters	Yes No Sexually Transmitted Disease	Yes No Are you nursing?
Yes No Frequent Headaches	Yes No Shingles	

Nearest relative not living with you:_____Relationship:_____
Address:_____Phone:_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature:_____Date:_____