Julia Lee, DDS, Inc.
& ASSOCIATES

HEALTH HISTORY

Patient Name: _____ Date: _____
Date of last health care exam: _____ What was this exam for? _____
Have you been hospitalized in the last 5 years? Yes No
If yes, please write the reason:_____
Are you currently receiving care: Yes No
Please list all the names and phone numbers of the physicians who are currently providing your care:
1. _____
2. _____

For the following questions, please circle Yes or No. Your answers are for our records only and will be confidential. Please note that during your initial visit, you will be asked some questions about your responses. Our team may ask additional questions concerning your health.

Abnormal Heart or previous Bacterial Endocarditis	Yes	No	Hepatitis	Yes	No
Allergies (Seasonal)	Yes	No	HIV Infection / AIDS or ARC	Yes	No
Anemia or Blood disorder	Yes	No	Immune system disorder	Yes	No
Arthritis, Rheumatism or other inflammatory disease	Yes	No	Diabetes	Yes	No
Liver Disease (including Jaundice)	Yes	No	Kidney Disease	Yes	No
Abnormal bleeding from a cut	Yes	No	Asthma	Yes	No
Cancer or Tumor	Yes	No	Migraines	Yes	No
Congenital Heart Disease	Yes	No	Previous Biopsies	Yes	No
Joint Replacement (if 'yes, when? _____)	Yes	No	Psychosis	Yes	No
Emphysema or other Respiratory/Lung Illnesses	Yes	No	Radiation or Chemotherapy	Yes	No
Epilepsy	Yes	No	Rheumatic Fever	Yes	No
Fainting or Dizzy spells	Yes	No	Sinus Problems	Yes	No
Gastroesophageal Reflux Disease (GERD)	Yes	No	Slow-healing mouth sores	Yes	No
Glaucoma	Yes	No	Sore / Enlarged Lymph nodes	Yes	No
Heart disease, Heart attack, Heart surgery	Yes	No	Stroke	Yes	No
Heart Stent (If '*yes*', when? _____)	Yes	No	Unintentional weight loss / gain	Yes	No
Heart Pacemaker	Yes	No	Venereal Disease	Yes	No
Heart Valve Replacement(Artificial) or Heart Transplant	Yes	No	Other Conditions	Yes	No

Are you currently taking any of these following medications? Circle Yes or No for each medication(s).

Pre-medication before dental treatment	Yes	No	Antacids	Yes	No
Tagamet (cimetidine) or Prilosec (omeprzole)	Yes	No	Dilantin or Tegretol	Yes	No
Cardizem (diltiazem) or Calan, Isoptin (verapamil)	Yes	No	Serzone (nefazodone)	Yes	No
Barbiturates (any)	Yes	No	Biaxin (clarithromycin)	Yes	No
Diflucan (fluconazole) or Sporonox (itraconazole)	Yes	No	St. John's Wort or Kava-Kava	Yes	No

Have you been treated with Bisphosphonate meds (Fosamax, Aredia, Zometa, Actonel, Boniva)? Yes No
If yes, when did the treatment begin? _____ When did the treatment end? _____
Have you ever taken any prescription drugs such as Fen-Phen for weight loss? Yes No
Do you consume grapefruit juice, grapefruits, or grapefruit extract? Yes No

Please list any medications you are currently taking and dosages:
1._____ 4._____
2._____ 5._____
3._____ 6._____
Please list any dietary or herbal supplements you are taking, and for what purpose:
1._____ 4._____
2._____ 5._____
3._____ 6._____

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Do you have abnormal Blood Pressure? Yes No
Have you been diagnosed with Hypertension (High Blood Pressure)? Yes No
Today's Blood Pressure is: _____ / _____ Pulse: _____

WOMEN:
Are you pregnant? Yes No
If no, are you planning a pregnancy in the near future? Yes No
Are you a nursing mother? Yes No
Are you taking birth control pills? Yes No

ALLERGIES:
Are you allergic or have you had an abnormal reaction to the following:
Local Anesthetics Yes No
Penicillin or other antibiotics Yes No
If yes to 'other', please list:_____
Aspirin, Ibuprofen, or Tylenol Yes No
Codeine, Valium, or other sedatives Yes No
Latex or Metals Yes No
Others (please specify):_____

TOBACCO, ALCOHOL, RECREATIONAL DRUGS
Do you use tobacco? Yes No
If yes, circle type: Smoke Chew How much per day?_____ For how long?_____
Do you want to quit using tobacco? Yes No
Do you consume Alcohol? Yes No
If 'yes', approximately how many alcoholic beverages per week? _____
Do you use any mood altering drugs other than those previously listed? Yes No
If 'yes', please list: _____

SLEEP APNEA
Do you have frequent heavy snoring? Yes No
Do you have significant daytime drowsiness? Yes No
Have you been told you stop breathing while sleeping? Yes No
Do you gasp at times when waking up? Yes No
Do you feel un-refreshed in the morning? Yes No
Do you have morning headaches? Yes No
What is your usual bedtime? _____ Wake time _____
Are you aware of any teeth grinding at night? Yes No
Do you often experience nasal congestion? Yes No
Do you wear CPAP? Yes No
If 'yes', since when? _____
Which of the following do you own?
Retainer Night Guard Sleep appliance CPAP Sport Guard

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, the office has my permission to ask the respective health care provider or agency, who may release such information to the office. I will notify the doctor of anychanges in my health and medications.

Patient Name (print): _____ Signature _____ Date _____

Doctor Name (print): Julia Lee, DDS / Danny Lee, DDS Signature _____ Date _____

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