CD
Corinium Dental

**Corinium Dental**
**Yoodong Moon D.D.S.**
2215 W. Schaumburg Rd.
Schaumburg, IL 60194

847-352-5410

# HEALTH HISTORY FORM

**Patient Name** _____ **Date of Birth** _____/_____/_____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provider appropriate care for you. This office does not use this information to discriminate.

## DENTAL INFORMATION

**What is the reason for your dental visit today?**

| | Yes | No |
|---|---|---|
| Are you having any discomfort/pain at this time? If so, please explain: _____ | ☐ | ☐ |
| Have you ever had any serious problems associated with previous dental treatment? | ☐ | ☐ |
| Do your gums bleed when you brush or floss? | ☐ | ☐ |
| Are your teeth sensitive to cold, hot, sweets or pressure? | ☐ | ☐ |
| Are your teeth loose? | ☐ | ☐ |
| Do you have unpleasant taste or bad breath? | ☐ | ☐ |
| Do you have burning sensation on your tongue and lips? | ☐ | ☐ |
| Does food or floss catch between your teeth? | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Is your mouth dry? | ☐ | ☐ |
| Do you have earaches or neck pains? | ☐ | ☐ |
| Do you clench or grind your teeth? | ☐ | ☐ |
| Do you have any clicking popping or discomfort in the jaw? | ☐ | ☐ |
| Do you have any swellings or lumps in your mouth? | ☐ | ☐ |
| Do you have sores or ulcers in your mouth? | ☐ | ☐ |
| Do you wear dentures or partials? | ☐ | ☐ |
| Have you ever been treated for periodontal (gum) treatments? | ☐ | ☐ |
| Have you ever had orthodontic (braces) treatments? | ☐ | ☐ |
| Have you ever had a serious injury to your head or mouth? | ☐ | ☐ |

## MEDICAL INFORMATION

| | Yes | No |
|---|---|---|
| Are you now under the care of a physician?<br>Physician Name: Phone: ( )<br>Address: | ☐ | ☐ |
| Date of last physical exam: _____ | | |
| Has there been any changes in your general health within past 2 years?<br>If yes, what condition is being treated?<br>_____ | ☐ | ☐ |
| Have you had a serious illness, operation or been hospitalized in past 5 years? | ☐ | ☐ |
| If yes, what was the illness or problem?<br>_____ | | |

| | Yes | No |
|---|---|---|
| Are you taking any prescription or over the counter medicine(s)?<br>If so, please list all. | ☐ | ☐ |
| Do you currently or have you ever used recreational drugs? | ☐ | ☐ |
| Do you use tobacco (smoking, snuff, chew, bidis)?<br>If so, how much per day? _____ | ☐ | ☐ |
| **WOMEN ONLY**. Are you: | **Yes** | **No** |
| Pregnant?<br>If yes, number of weeks: _____ | ☐ | ☐ |
| Taking birth control pills or hormonal replacement? | ☐ | ☐ |
| Nursing? | ☐ | ☐ |
| | ☐ | ☐ |

| **Allergies**- Are you allergic to or have you ever had a reaction to: (To all yes responses, specify type of reaction.) | **Yes** | **No** |
|---|---|---|
| Penicillin or other antibiotics _____ | ☐ | ☐ |
| Aspirin _____ | ☐ | ☐ |
| Sulfa drugs _____ | ☐ | ☐ |
| Barbiturates, sedatives, or sleeping pills _____ | ☐ | ☐ |
| Codeine or other narcotics _____ | ☐ | ☐ |
| Local Anesthetics _____ | ☐ | ☐ |
| Metals _____ | ☐ | ☐ |
| Latex (rubber) _____ | ☐ | ☐ |
| Iodine _____ | ☐ | ☐ |
| Hay fever/seasonal _____ | ☐ | ☐ |
| Other _____ | ☐ | ☐ |

| **Joint Replacement.** | **Yes** | **No** |
|---|---|---|
| Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? . . . . . Date: _____ Any complications? | ☐ | ☐ |

| Are you taking or schedule to begin taking either of the medications, alendronate (Fosamax) or risedronate (Actonel) for osteoporosis or Paget's disease? . . . . . | **Yes** ☐ | **No** ☐ |
|---|---|---|

| Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date Treatment began: _____ | **Yes** ☐ | **No** ☐ |
|---|---|---|

**Please mark (X) your response to indicate if you have or have not had any of the following disease or problems.**

| | Yes | No |
|---|---|---|
| Artificial (prosthetic) heart valve | ☐ | ☐ |
| Previous infective endocarditis | ☐ | ☐ |
| Damaged valves in transplanted heart | ☐ | ☐ |
| Congenital heart disease (CHD) | ☐ | ☐ |
| Unrepaired, cyanotic CHD | ☐ | ☐ |
| Repaired (completely) in last 6 months | ☐ | ☐ |
| Repaired CHD with residual defects | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Abnormal bleeding | ☐ | ☐ |
| AIDS or HIV infection | ☐ | ☐ |
| Alzheimer's disease | ☐ | ☐ |
| Anaphylaxis | ☐ | ☐ |
| Anemia | ☐ | ☐ |
| Angina | ☐ | ☐ |
| Arteriosclerosis | ☐ | ☐ |
| Arthritis | ☐ | ☐ |
| Asthma | ☐ | ☐ |
| Autoimmune disease | ☐ | ☐ |
| Blood transfusion | ☐ | ☐ |
| If yes, date: _____ | | |
| Bronchitis | ☐ | ☐ |
| Bruise easily | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Damaged heart valves | ☐ | ☐ |
| Diabetes Type I or II | ☐ | ☐ |
| Eating disorder | ☐ | ☐ |
| Emphysema | ☐ | ☐ |
| Epilepsy | ☐ | ☐ |
| Excessive bleeding | ☐ | ☐ |
| Excessive urination | ☐ | ☐ |
| Fainting spells or seizures | ☐ | ☐ |
| G.E Reflux/persistent heartburn | ☐ | ☐ |
| Gastrointestinal disease | ☐ | ☐ |
| Glaucoma | ☐ | ☐ |
| Heart attack | ☐ | ☐ |
| Heart murmur | ☐ | ☐ |
| Hemophilia | ☐ | ☐ |

| | Yes | No |
|---|---|---|
| Mental health disorders | ☐ | ☐ |
| If yes, Specify: _____ | | |
| Mitral valve prolapse | ☐ | ☐ |
| Neurological disorder | ☐ | ☐ |
| If yes, specify: _____ | | |
| Night sweats | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ |
| Pacemaker | ☐ | ☐ |
| Parathyroid disease | ☐ | ☐ |
| Persistent swollen glands in neck | ☐ | ☐ |
| Recurrent infections | ☐ | ☐ |
| Type of infection: _____ | | |
| Renal Dialysis | ☐ | ☐ |
| Rheumatic fever | ☐ | ☐ |
| Rheumatic heart disease | ☐ | ☐ |
| Rheumatoid arthritis | ☐ | ☐ |
| Scarlet fever | ☐ | ☐ |
| Severe headaches/migraines | ☐ | ☐ |
| Severe or rapid weight loss | ☐ | ☐ |
| Sexually transmitted disease | ☐ | ☐ |
| Shingles | ☐ | ☐ |
| Sinus trouble | ☐ | ☐ |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Cancer/Chemotherapy/ Radiation Treatment . . . . . | ☐ | ☐ | Hepatitis, jaundice, liver disease | ☐ | ☐ | Sleep disorder . . . . . | ☐ | ☐ |
| | | | High blood pressure . . . . . | ☐ | ☐ | Stroke . . . . . | ☐ | ☐ |
| Cardiovascular disease . . . . . | ☐ | ☐ | Hypoglycemia . . . . . | ☐ | ☐ | Systemic lupus erythematosus . . | ☐ | ☐ |
| Chest pain upon exertion . . . . . | ☐ | ☐ | Kidney problems . . . . . | ☐ | ☐ | Thyroid problems . . . . . | ☐ | ☐ |
| Chronic pain . . . . . | ☐ | ☐ | Low blood pressure . . . . . | ☐ | ☐ | Tuberculosis . . . . . | ☐ | ☐ |
| Congestive heart failure . . . . . | ☐ | ☐ | Malnutrition . . . . . | ☐ | ☐ | Ulcers . . . . . | ☐ | ☐ |
| Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? . . . . . | | | | | | | ☐ | ☐ |
| Do you have any disease, condition, or problem not listed above that you think we should know about? . . . . . Please explain: | | | | | | | ☐ | ☐ |

I certify that I have read and understand the above that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

**Signature of Patient/Legal Guardian: _____ Date: _____**

If this Health History Form is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____ Relationship to Patient: _____

**Signature of Dentist _____**