Surf City Dentist
Ken Yabuki, D.D.S.
Jeff Coleman, D.D.S.
www.surfcitydentist.com

MEDICAL HISTORY

Todays Date _____

Name _____ Marital Status _____ Sex _____ Date of Birth _____
Email _____
Address _____ Home/Cell Phone _____
Street City Zip
Work Phone _____
Former Dentist _____ How Long? _____
Name Phone
Physician _____
Name Address Phone
Referred By: _____ Reason: _____
Employed By: _____ Occupation: _____

1. Have you had any medical care or surgeries within the past two years?..... ☐ Yes ☐ No
   Describe _____
2. Are you currently **taking any medication, drugs, pills, or herbal remedies**, including regular dosages of aspirin? ☐ Yes ☐ No
   If Yes, please list:_____
   _____
3. Do you use Tobacco/Nicotine in any form? ☐ Smoke ☐ Chewing ☐ E-cigs/Vape ☐ Other Form ☐ Yes ☐ No
4. Have you ever taken bone loss prevention drugs such as **Fosamax, Actonel, Boniva,** or other similar drugs?..... ☐ Yes ☐ No
5. Have you **EVER had an ADVERSE or ALLERGIC reaction** to any substance or medication?..... ☐ Yes ☐ No
   If Yes, please specify _____
6. Have you ever been diagnosed and/or treated for Sleep Apnea? ☐ Yes ☐ No
7. Do you have any of the following symptoms? ☐ Daytime Sleepiness ☐ Snoring ☐ Waking Gasping for Air
8. Indicate **which** of the following **you have had**, or **have at present**. Check "Yes" or "No" to each item:

Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No	Hepatitis A, B, C	☐ Yes	☐ No
			Thyroid Problems	☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
Congenital Heart Problems	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Dry Mouth	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Difficulty Swallowing	☐ Yes	☐ No
Artificial Heart Valve	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Hemophilia/Bleeding Disorder	☐ Yes	☐ No
Pacemaker/Defibrillator	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Cortisone Medication	☐ Yes	☐ No	Hay Fever/Allergy/Hives	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Latex Sensitivity/Allergy	☐ Yes	☐ No	Alzheimers or Dementia	☐ Yes	☐ No
Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
			Radiation Therapy	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No	Chemotherapy	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No
Arthritis/Joint Pain	☐ Yes	☐ No	Tumors/Cancer	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Organ Transplant	☐ Yes	☐ No	Autoimmune Disease	☐ Yes	☐ No			

9. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
   If Yes, please specify _____
10. Women: Are you Pregnant or think you could be pregnant? ☐ Yes, ___ Months ☐ No Nursing? ☐ Yes ☐ No

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, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medications.

Patient/Guardian Signature _____ Date _____
Comments:

Provider Signature _____ Date _____