



# Dr. David Bishop and Dr. Robert Kim

1104 N. GREENVILLE AVENUE,

ALLEN, TEXAS 75002

972.727.8249

## MEDICAL HISTORY

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|----|---|-----|----|
| 1. | Have you been under the care of a medical doctor during the past two years?<br>If yes, for what reason? _____   | YES | NO |
| 2. | Are you having dental problems at this time?  | YES | NO |
| 3. | Do your gums bleed at any time?   | YES | NO |
| 4. | Do you feel very nervous about having dental treatment?   | YES | NO |
| 5. | Are you allergic to (i.e. itching, rash, swelling or hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications?<br>If yes, please list _____ | YES | NO |
| 6. | Have you ever had excessive bleeding requiring special treatment?   | YES | NO |
| 7. | Check any of the following which you have had or have present:  | YES | NO |

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Ulcer                           | <input type="checkbox"/> HIV Positive (AIDS)          |
| <input type="checkbox"/> Tuberculosis (TB)      | <input type="checkbox"/> Shortness of Breath             | <input type="checkbox"/> Hepatitis A (Infectious)     |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hepatitis B (Serum)             | <input type="checkbox"/> High Blood Pressure          |
| <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Liver Disease                   | <input type="checkbox"/> Heart Murmur/ Mitral Valve   |
| <input type="checkbox"/> Scarlet Fever          | <input type="checkbox"/> Diabetes                        | <input type="checkbox"/> Bruise Easily                |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Thyroid Disease                 | <input type="checkbox"/> Artificial Heart Valve       |
| <input type="checkbox"/> Heart Pacemaker        | <input type="checkbox"/> Chemotherapy (Cancer, Leukemia) | <input type="checkbox"/> Drug Addiction               |
| <input type="checkbox"/> Heart Surgery          | <input type="checkbox"/> Arthritis                       | <input type="checkbox"/> Hemophilia                   |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Cortisone Medication            | <input type="checkbox"/> Cold Sores or Fever Blisters |
| <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Glaucoma                        | <input type="checkbox"/> Epilepsy or Seizures         |
| <input type="checkbox"/> Kidney Trouble         | <input type="checkbox"/> Pain in Jaw Joints              | <input type="checkbox"/> Nervousness                  |

- |  |     |    |
|--|-----|----|
| • Do you have any disease, condition or problem not listed? If so, please list _____ | YES | NO |
|--|-----|----|

- |     |  |     |    |
|-----|--|-----|----|
| 8.  | List all medications you are taking at this time _____           |     |    |
| 9.  | Are you a smoker?  | YES | NO |
| 10. | Do you use or have you used recreational drugs?                  | YES | NO |
| 11. | Do you ever wake up from sleep short of breath? Do you snore?    | YES | NO |
| 12. | Do you clench your teeth?  | YES | NO |
| 13. | Has your medication doctor ever said you have cancer or a tumor? | YES | NO |
| 14. | Women: are you pregnant? YES NO If yes, what month are you due?  |     |    |
- How do you feel about getting and maintaining a healthy mouth?  
\_\_\_\_\_
  - How do you feel about the appearance of your teeth?  
\_\_\_\_\_
  - If you could change anything about your smile what would you change?  
\_\_\_\_\_

Updates (date and initial) \_\_\_\_\_