Divine
DENTAL SOLUTIONS

Dr. Ly Patient #________________

Dental Practice of Vang (Peter) Ly, D.D.S.

Patient Medical History

☐ Yes ☐ No Have you been ill lately? ______________________________

☐ Yes ☐ No Are you presently under the care of a physician? ____________________

☐ Yes ☐ No Have you ever been hospitalized? __________________________

☐ Yes ☐ No Are you pregnant? ________________________________

☐ Yes ☐ No Are you currently taking any medications, including prescriptions, over-the-counter, or herbal supplements? If yes, explain: ____________________________

☐ Yes ☐ No Do you have any allergies to medications? __________________________

☐ Yes ☐ No Have you ever had any adverse reaction to local anesthetic? If yes, explain: ____________

☐ Yes ☐ No Have you ever had a joint replacement? If yes, explain: ____________________

Please List your Primary Care Physician, if you have one:

His/Her Name:____

His/Her Phone:____

Do you have or have you ever had any of the following? (Please check Yes or No)

☐ Yes ☐ No Alcohol Use
☐ Yes ☐ No Allergies or Hives
☐ Yes ☐ No Anemia
☐ Yes ☐ No Angina Pectoris
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Artificial Heart Valve
☐ Yes ☐ No Artificial Joints
☐ Yes ☐ No Asthma
☐ Yes ☐ No Blood Disorder
☐ Yes ☐ No Blood Transfusion
☐ Yes ☐ No Cancer
☐ Yes ☐ No Chemotherapy
☐ Yes ☐ No Cold Sores
☐ Yes ☐ No Congenital Heart Defect
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Drug Addiction/Use
☐ Yes ☐ No Eating Disorder
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Epilepsy or Seizures
☐ Yes ☐ No Fainting/Dizziness
☐ Yes ☐ No Hearing Impairment
☐ Yes ☐ No Heart Disease/Attack
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Heart Pacemaker
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No Kidney Trouble
☐ Yes ☐ No Latex Allergies
☐ Yes ☐ No Persistent Cough
☐ Yes ☐ No Psychiatric Disorders
☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Recreational Drug Use
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No STD's (Sexually Transmitted Disease)
☐ Yes ☐ No Stroke
☐ Yes ☐ No Thyroid Problems
☐ Yes ☐ No Tobacco Use
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Visual Disorder
☐ Yes ☐ No Other

If you marked ***Yes*** on any of the above, please explain:

____

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____

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Patient Dental History

Name of Previous Dentist and Location______________________ Date of Last Exam__________

Why did you come to the dentist today, and are you in pain?

____

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1. Do you experience stress or anxiety when you visit a dental office?.... ☐ Yes ☐ No
2. Do your gums bleed while flossing or brushing?.................................. ☐ Yes ☐ No
3. Are your teeth sensitive to hot or cold liquids/foods?.......................... ☐ Yes ☐ No
4. Are your teeth sensitive to sweet or sour liquids/foods?.................... ☐ Yes ☐ No
5. Do you feel pain to any of your teeth?.. ☐ Yes ☐ No
6. Do you have any sores or lumps in or near your mouth?...................... ☐ Yes ☐ No
7. Have you had any head, neck, or jaw injuries?.................................... ☐ Yes ☐ No
8. Have you ever experienced any of the following in your jaw?
   a. Clicking.. ☐ Yes ☐ No
   b. Pain (joint, ear, side of face).. ☐ Yes ☐ No
   c. Difficulty in opening or closing.. ☐ Yes ☐ No
   d. Difficulty in chewing.. ☐ Yes ☐ No
9. Do you have frequent headaches?.. ☐ Yes ☐ No
10. Do you clench or grind your teeth?.. ☐ Yes ☐ No
11. Do you bite your lips or cheeks frequently?.. ☐ Yes ☐ No
12. Have you ever had any difficult extractions in the past?...................... ☐ Yes ☐ No
13. Have you ever had any prolonged bleeding following extractions?.... ☐ Yes ☐ No
14. Have you had any orthodontic treatment?... ☐ Yes ☐ No
15. Do you wear dentures or partials?.. ☐ Yes ☐ No
    If Yes, Date of Placement____________
16. Have you ever received oral hygiene instructions
    regarding the care of your teeth and gums?.. ☐ Yes ☐ No
17. Do you like your smile?.. ☐ Yes ☐ No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform this office of any changes in my medical status.

X______________________________

Signature of Patient (or Parent if Minor)

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Date