GEAUXSMILES
HUNG HOANG DDS AND ASSOCIATES

Geaux Smiles
406 Lafayette St.
Gretna, LA 70053
(P) (504) 366-3052
(F) (504) 366-9201

Medical History

Patient Information

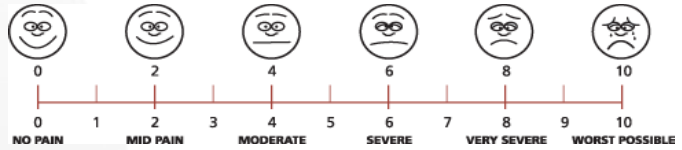
Name: ____ Date of Birth: _______/_______/_______

Dental History

Previous Dentist: ____ Last Visit: _______/_______/________

Currently experiencing pain? Yes No

If yes, indicate pain level: _____



	Yes		No		Unsure
Do you bleed excessively after tooth extractions?					
Have you had pain or swelling for more than two weeks after surgery to the jaw?					
Any serious reactions to local/general anesthetics, nitrous oxide?					
Have you ever had serious trouble associate with any previous dental treatment?					
Do you have any soft tissue sores or bumps in your mouth?					
Do you clench or grind your teeth?					
Are any teeth sensitive to cold or sweets?					
Has a doctor told you to take antibiotics BEFORE having dental treatment?					

Medical History

	Yes		No		Unsure
Are you being treated by a medical doctor now?					
Reason: Physician's Name:					
Are you taking any medications at the present time?					
List:					
Have you ever taken medication to relieve anxiety or depression?					
Sensitive or allergic to any medication or to latex gloves/products?					
Have you ever been hospitalized or had any surgical operations?					
Ever had excessive bleeding from a cut or wound?					
Have you ever had cancer? If yes, what kind?					
Do you have pain in the chest upon exertion?					
Shortness of breath after mild exercise or exertion?					
Do your ankles swell or do you bruise easily?					
Use extra pillows to help you breathe better while sleeping?					
Do you have to urinate frequently?					
Are you thirsty and/or hungry much of the time?					
Have you lost or gained weight in the last year? Reason:					
Has a doctor ever said you had infectious diseases (ex: HIV, hepatitis C)					
Do you have difficulty with swallowing, breathing, or snoring?					
Do you have frequent infections?					
Do you have frequent headaches or migraines?					
Do you currently or have you in the past used tobacco products/alcohol?					

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Cardiovascular

	Yes	No	Unsure
Heart failure			
Heart attack or disease			
Angina Pectoris or chest pains			
Acute coronary syndrome			
High blood pressure			
Heart murmur			
Mitral valve prolapsed			
Rheumatic fever			
Congenital heart defect or lesion			
Irregular heart beat			
Heart pacemaker or defibrillator			
Heart surgery or transplant			
Other heart problems			
Stroke			
Aneurysm			

Blood/Oncology

	Yes	No	Unsure
Blood transfusion			
Anemia			
Sickle cell disease			
Leukemia			
Clotting disorder or hemophilia			
Tendency to bleed longer than normal			
Chemotherapy			
Radiation treatment			

Endocrine

	Yes	No	Unsure
Diabetes			
Thyroid disease			
Steroid therapy			

Neural/Psychiatric

	Yes	No	Unsure
Eye pain			
Vision problems			
Glaucoma			
Earaches/ringing in ears			
Hearing loss			
Severe headaches			
Fainting or dizzy spells			
Epilepsy, seizures, or convulsions			
Nervousness			
Psychiatric treatment			
Depression			
Schizophrenia			
Bipolar			
Alcohol or substance abuse			

Gastrointestinal

	Yes	No	Unsure
Gastritis/ulcers/reflux disease			
Ulcerative colitis			
Crohn’s disease			
Persistent diarrhea/constipation			
Hepatitis			
Liver disease			
Yellow jaundice			
Cirrhosis			

Respiratory

	Yes	No	Unsure
Chronic bronchitis			
Emphysema			
Asthma			
Respiratory allergies			
Chronic cough			
Sinus trouble			
Tuberculosis (TB)			
Breathing difficulties			
Flu-like symptoms			

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Skin/Mucosa/Musculoskeletal

	Yes	No	Unsure
Allergy to latex (rubber gloves)			
Skin rash			
Dark mole(s) or recent changes			
Melanoma			
Fibromyalgia			
Sore muscles			
Stiff joints			
Arthritis or gout			
Artificial joint			
Osteoporosis			
Medicines for osteoporosis/bone cancer			
Intravenous (IV) bisphosphonates			

Genitourinary

	Yes	No	Unsure
Sexually transmitted disease (STD)			
Kidney(renal) dialysis			
Kidney/bladder problems			
Urinate frequently			

Oral Medicine/Facial Pain

	Yes	No	Unsure
Mouth ulcers or fungus (candidiasis)			
White/red patches in the mouth			
Dry mouth or burning tongue			
Pain in facial muscles			
TMJ problems			
Nerve pain			
Autoimmune disorders			

Other Conditions

	Yes	No	Unsure
Enlarged lymph node or gland			
Head and neck cancer			
Hyperbaric oxygen therapy			
Organ or cell transplant			
Disease, problems, or condition not listed			
List:			

Females

	Yes	No	Unsure
Are you pregnant?			
Do you plan to become pregnant soon?			
Did you have any complications during pregnancy?			
Do you have trouble with your period?			

To the best of my knowledge all the answers on all pages are true and correct. If I have a change in my health information, I will inform my dentist at my next appointment.

________________________________ ________________________________

Signature of Patient or Guardian Date