SHANAHAN & CHEUNG DDS, PC
"Where general dentistry becomes individualized"

Medical History

3941 75th St #103
Aurora, IL 60504
(630)375-8380
www.ShanahanCheungDDS.com

Patient Name (last)_____ (first)_____ (preferred)_____

DOB ____/_____/____ Gender: ☐Male ☐Female Family Status: ☐Married ☐Single ☐Child ☐Other

Phone: Home_____ Cell_____ Work_____

Email: _____

Address: _____

1. Are you in good health? ☐Yes ☐No Have there been any changes in your general health within the past year?

☐ Yes ☐ No? (if yes, please describe) _____

2. Have you had any serious illness, operation, or hospitalization within the past 5 years? ☐Yes ☐No

If yes, please describe _____

3. Are you currently under the care of a physician for a specific health concern? ☐Yes ☐No If so, describe the condition(s) being treated?

_____

Name / address of physician _____

Phone number of physician _____

4. Are you taking any medications (including non-prescription)? ☐Yes ☐No If so, what medicine(s) are you taking?

_____

_____

5. Are you allergic to any of the following?

☐ Local anesthetics ☐ Iodine ☐ Codeine or other narcotics
☐ Aspirin ☐ Latex ☐ Penicillin or other antibiotics
☐ Sulfa drugs ☐ Barbiturates, sedatives, or sleeping pills
☐ Other_____

6. Do you have any of the following cardiovascular concerns?

☐ Angina	☐ Arteriosclerosis	☐ Heart disease
☐ Heart murmur	☐ High blood pressure	☐ Rheumatic heart disease
☐ Pacemaker	☐ Mitral valve prolapse	

7. Do you have any of the following conditions?

☐ Allergies	☐ Sinus trouble	☐ Eating disorder
☐ Kidney trouble	☐ Epilepsy / seizures	☐ Diabetes
☐ Cancer	☐ AIDS or HIV	☐ Sexually transmitted disease
☐ Abnormal bleeding	☐ Tuberculosis	☐ Stomach ulcer or hyperacidity
☐ Respiratory problems	☐ Liver disease	☐ Problems with mental health
☐ Blood disorder/anemia	☐ Persistent swollen glands	☐ Problems with immune system

If so, please describe your condition _____

8. Have you had an orthopedic total joint replacement? ☐Yes ☐No If so, when?_____

9. Has a physician or prior dentist recommended that you take antibiotics prior to dental treatment? ☐Yes ☐No

What was the prescribed antibiotic and dose? _____

Name of the physician or dentist: _____

If premedication is needed, is it required for lifetime? ☐Yes ☐No

Women Only

Are you pregnant? ☐Yes ☐No

Are you nursing? ☐Yes ☐No

Are you taking birth control pills? ☐Yes ☐No

Signature_____

Date_____