DR. SCOTT B. YAMAOKA, D.D.S., M.S.

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MEDICAL-DENTAL ALERT

CONFIDENTAL PERSONAL INFORMATION

Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Last Name | First Name | Middle Initial | Birthdate (DD/MM/YY) ___/___/___

Address | City / Province | Postal Code

Home Telephone: | Work: | Cell:

Best Phone # to call ☐ Home ☐ work ☐ Cell | Email Address:

Do you have a general dentist? ☐ Yes ☐ No | Name:

Personal Physician: | Phone Number:

In case of emergency, please notify: Name: | Relationship: | Phone:

MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition and give the highest possible standard of professional services.
ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL.

Please check (✓) NOTES

1. How would you rate your general health ..... ☐ Good ☐ Fair ☐ Poor ☐ Don't Know
2. Have you had or do you have any serious medical illness? ..... ☐ Yes ☐ No _____
3. Are you now under the care of a physician for a medical condition? ..... ☐ Yes ☐ No _____
4. Are you being treated for osteoporosis or osteopenia? ..... ☐ Yes ☐ No _____
5. What pills or medication do you take on a daily basis? _____
6. What pills or medication have you taken in the last year? _____
7. Have you experienced any unusual reaction to any of the following drugs? ☐ Yes ☐ No _____

(Please circle) aspirin iodine barbiturates (sleeping pills) penicillin sulfamide (sulfa) tetracyclines other medicine: _____

8. Do you have, or have you had, any of the following conditions:

☐ Heart Failure	☐ Artificial Joint	☐ Asthma	☐ Leukemia	☐ Drug Addiction
☐ Heart Disease or Attack	☐ Scarlet Fever	☐ Hay Fever	☐ Arthritis	☐ Venereal Diseases
☐ Angina	☐ Anaemia	☐ Sinus Trouble	☐ Rheumatism	☐ AIDS
☐ High Blood Pressure	☐ Blood Disorders	☐ Allergies or Hives	☐ Cortico Steroid / Medication	☐ Cold Sores
☐ Heart Murmur	☐ Stroke	☐ Diabetes		☐ Epilepsy or Seizures
☐ Rheumatic Fever	☐ Kidney Trouble	☐ Family History of Diabetes	☐ Glaucoma	☐ Fainting or Dizzy Spells
☐ Congenital Heart Lesions	☐ Ulcers	☐ Thyroid Disease	☐ Hepatitis	☐ Psychiatric Treatment
☐ Artificial Heart Valve	☐ Emphysema	☐ Cancer	☐ Liver Disease	☐ Extreme Nervousness
☐ Heart Pacemaker	☐ Prolonged Cough	☐ X-ray or Cobalt Treatment	☐ Hemophilia	☐ Frequent Severe Headaches
☐ Heart Surgery	☐ Tuberculosis (TB)	☐ Chemotherapy	☐ Blood Transfusion	

Please turn over →

9. Do you smoke?..... ☐ Yes ☐ No If yes, how much _____
10. Did you ever smoke?..... ☐ Yes ☐ No If yes, how much _____
11. When did you stop?_____
12. How many alcoholic drinks do you have? In a day _____ In a week _____

WOMEN: Are you pregnant now?..... ☐ Yes ☐ No _____

Do you anticipate becoming pregnant in the near future?.... ☐ Yes ☐ No _____

Are you taking oral contraceptives or other hormones?..... ☐ Yes ☐ No _____

_____

14. Have you ever had intravenous sedation or general anesthetic? ☐ Yes ☐ No _____

- if Yes - any complications with either?_____

DENTAL HISTORY

1. Main dental complaint or problem _____
2. How long have you known about your gum condition? _____
3. What kind of gum treatment have you had previously? ☐ None ☐ Regular Cleaning ☐ Deep Cleaning / Scaling ☐ Gum Surgery
4. How frequently do you have your teeth cleaned at the dentist? _____

   When were they done last?_____
5. How often do you clean your teeth in a day? _____

   Circle the items you use to clean your mouth.

Manual Toothbrush	Dental Floss	Water Pik	Baking Soda / Salt
Electric Toothbrush	Proxi Brush	Rubber Tip	Tooth Picks

6. Do you feel that you have bad breath at times?..... ☐ Yes ☐ No
7. Do your gums bleed or hurt when you brush or eat?..... ☐ Yes ☐ No
8. Are your teeth sensitive to hot, cold, or sweets? ..... ☐ Yes ☐ No
9. Do your jaws feel stiff, sore or tired when you awaken?..... ☐ Yes ☐ No
10. Do you grind or clench your teeth at night?..... ☐ Yes ☐ No
11. Have you noticed any loose, shifting or tipped teeth?..... ☐ Yes ☐ No
12. Are you happy with your smile and the esthetics of your teeth?..... ☐ Yes ☐ No

    if no, what would you change?_____

To the best of my knowledge, all of the preceding answers are true and correct. If there are any changes in my health or medications, I will inform Dr. Yamaoka at the next appointment.

I am responsible for all fees associated with the procedures performed by Dr. Yamaoka. Please Initial: _____

Dr. Yamaoka and his team make every effort to accommodate you and your schedule. If you need to reschedule or cancel your appointment, we require notification of 2 of our business days. Please note that our office is closed on Fridays. We reserve the right to charge your account for appointments missed or cancelled without appropriate notice. Please initial: _____

_____	_____	_____
Patient, Parent or Guardian Signature	Date	Dr. Scott Yamaoka Signature