LEE DENTAL
OF ARLINGTON HEIGHTS

Alisa You Yeon Lee DDS
General Dentistry for the Families

637 E Golf Rd. Suite 205
Arlington Heights, IL 60005
847-593-6480
www.leedentalah.com

MEDICAL HISTORY

Date_____/_____/_____ Contact #: (_____)_____ ☐ Mobile ☐ Home landline

Patient_____
Last Name First Name Middle Initial

Sex ☐ M ☐ F Age_____ Date of Birth_____/_____/_____

Primary Physician's Name _____ Date of Last Physical_____

Have you ever had any of the following? (check boxes that apply):

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Nervous Problems
- ☐ Radiation Treatment
- ☐ Artificial Heart Valves
- ☐ Artificial Joints (e.g. hip, knee, etc.)
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Respiratory Disease
- ☐ Stomach or Intestinal Problems
- ☐ Epilepsy
- ☐ Headaches
- ☐ Hepatitis, Jaundice or Liver Disease
- ☐ Cancer
- ☐ Psychiatric Care
- ☐ Allergies to Anesthetics
- ☐ Allergies to Medicine or Drugs
- ☐ General Allergies
- ☐ Blood Disease
- ☐ Arthritis
- ☐ Fainting or Dizziness
- ☐ Glaucoma
- ☐ Swollen Neck Glands
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Immunosuppressive Disorders
- ☐ Stroke
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Chemical Dependency
- ☐ Bleeding Tendency
- ☐ Tuberculosis

Do you have any drug allergies or have you ever had an adverse reaction to any medication? If so, what_____

_____

Have you ever responded unfavorably to medical or dental treatment?_____

Are you taking any medication, drugs, or pills at this time? ☐ YES ☐ NO If yes, what_____

Are you under the care of a physician? ☐ YES ☐ NO If yes, for what condition(s)?_____

_____

Have you ever had chest pain? ☐ YES ☐ NO

Do you get short of breath, or have chest pain after a little exertion?_____

Is there anything else we should know about your medical history?_____

_____

[FOR WOMEN ONLY]

Are you pregnant? ☐ YES ☐ NO Are you nursing? ☐ YES ☐ NO Birth Control Pills ☐ YES ☐ NO

(PLEASE COMPLETE REVERSE SIDE)

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DENTAL HISTORY

What is the main purpose of your visit today? _____

On the scale of 1~10 (1=NOT concerned; 10=VERY concerned), please rate the current condition of the following.

											Comments
Gum pain/bleeding	1	2	3	4	5	6	7	8	9	10	
Tooth pain	1	2	3	4	5	6	7	8	9	10	
Jaw pain/click	1	2	3	4	5	6	7	8	9	10	
Neck/ear pain	1	2	3	4	5	6	7	8	9	10	
Wisdom tooth pain	1	2	3	4	5	6	7	8	9	10	
Tooth chipped/broken	1	2	3	4	5	6	7	8	9	10	
Filling/crown chipped/broken	1	2	3	4	5	6	7	8	9	10	
Bad breath	1	2	3	4	5	6	7	8	9	10	
Grinding/clenching/tooth wear	1	2	3	4	5	6	7	8	9	10	
Food caught between teeth	1	2	3	4	5	6	7	8	9	10	

		YES	NO
(1)	Do you have frequent headaches?	☐	☐
(2)	Do you have difficulty or discomfort with chewing?	☐	☐
(3)	Have you had braces?	☐	☐
(4)	Have you had your wisdom teeth extracted?	☐	☐
(5)	Have you been instructed in the proper way to care for your teeth and gums?	☐	☐
(6)	When was your last complete dental exam? _____/_____/_____		

On the scale of 1~10 (1=NOT interested; 10=VERY interested), please rate your interest in the following.

											Comments
Maintaining your natural teeth	1	2	3	4	5	6	7	8	9	10	
Improving teeth color/shape	1	2	3	4	5	6	7	8	9	10	
Changing metal fillings	1	2	3	4	5	6	7	8	9	10	
Improving teeth alignment	1	2	3	4	5	6	7	8	9	10	

Do you have other dental concerns?_____

The above information is true to the best of my knowledge.

Signature_____ Date_____/_____/_____
(Parent's signature if the patient is a minor)