MEDICAL HISTORY

Dr. Wook Kim, DDS
14600 South LaGrange Road Orland Park, IL 60462
Telephone # 708-349-3990

Today's Date _____

Last _____ First _____ M___ SS#_____
Address_____ City_____ State_____ Zip_____
Birthdate_____ Age___ Sex___ Height_____ Weight_____ Marital Status_____
HomePhone#_____ Cell#_____ Pager#_____
E-mail Address_____ Referred by_____
Occupation_____ Place of Employment_____ Work #_____
May we call you at work to confirm, change, or make an appointment?.....___Yes ___No
Person Responsible for Account_____ Do You Have Dental Insurance? ___Yes ___No
Who is the plan under? ___Yourself ___ Spouse ___Parent Plan Holders Birthday_____ SS#_____
Name of Insurance Co._____ Group #_____ Id# _____
General Health (please check one).....___Excellent ___Good ___Fair ___Poor
Has there been any change in your general health within the past year?..... ___Yes ___No
My last physical exam was _____
Name and phone number of my physician is_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering these questions.

Do you have or have you had any of the following:

___AIDS/HIV Positive	___ Emphysema	___Hepatitis B or C	___Renal Dialysis
___Alzheimer's Disease	___Epilepsy/Seizures	___Herpes	___Rheumatic Fever*
___Anemia	___Excessive Bleeding	___Hiatal Hernia	___ Rheumatism
___Angina	___Excessive Thirst	___ High Blood Pressure	___Scarlet Fever
___Arthritis/Gout	___Fainting Spells/Dizziness	___Hives/Rash	___Shingles
___Artificial Heart Valve*	___Frequent Cough	___ Hypoglycemia	___Sickle Cell Disease
___Artificial Joint*	___Frequent Diarrhea	___Irregular Heartbeat	___Sinus Trouble
___Asthma	___Frequent Headaches	___Kidney Problems	___Spina Bifida
___Blood Transfusion	___Gastro-Esophageal	___Leukemia	___Stomach/Intestinal
___Breathing Problems	Reflux Disorder (GERD)	___Liver Disease	___Disorder
___Bruise Easily	___Glaucoma	___Low Blood Pressure	___Stroke
___Cancer	___Hay Fever	___Lung Disease	___Swelling of Limbs
___Candida	___Hearing Problems	___Mitro Valve Prolapse*	___Thyroid Disease
___Chemotherapy	___Heart Attack/Failure	___Muscular Dystrophy	___Tonsillitis
___Chest Pains	___Heart Murmur*	___Pain in Jaw Joints	___Tuberculosis
___Cold Sores/Fever Blisters	___Heart Pace Maker*	___Parathyroid Disease	___Tumors/Growths
___Congenital Heart Disease	___Heart Trouble/Disease	___Psychiatric Care	___Ulcers
___Diabetes	___Hemophilia	___Radiation Treatments	___Venereal Disease
___Drug Addition	___Hepatitis A	___Recent Weight Loss	___Yellow Jaundice

*Condition may require medications for Dental Care
Is medication required?..... ___Yes ___No
If so, what type of medication do you take?_____
Have you ever been told you need pre-medication for dental treatment?..... ___Yes ___No
Have you ever had any serious illness or operation that is not listed above? ..... ___Yes ___No
Please Explain_____

Are you allergic to or have you reacted adversely to any of the following:

___Acetaminophen	___Barbiturates	___Iodine	___Metal
___Acrylic	___Codeine	___Latex	___Penicillin
___Aspirin	___Ibuprofen	___Local Anesthetics	___Sedatives

Are you taking any of the following medicines or drugs?

___Acetaminophen	___Birth Control Pills	___Insulin/Simular Drugs
___Antibiotics or Sulfa Drugs	___Cortisone	___Nitroglycerin
___Anticoagulants	___Digitalis or Heart Medicine	___ Tranquilizers
___Aspirin	___High Blood Pressure	

Please list any prescription medications, over-the-counter medications, herbal medications, and vitamins you are currently taking _____

Please Answer the Following Questions:

Have you had any serious trouble associated with previous dental treatment?.....___Yes ___No
Have you had any teeth extracted (taken out)?.....___Yes ___No
Have you had dry sockets after an extraction?.....___Yes ___No
Have you had any abnormal bleeding associated with previous extractions?.....___Yes ___No

Do you ever notice noises, clicks, or pops in your jaw?.....___Yes ___No
Do you clench or grind your teeth?.....___Yes ___No
Have you had orthodontic treatment?.....___Yes ___No

Does food catch between your teeth?.....___Yes ___No
Are your teeth loose or separating?.....___Yes ___No
Are your teeth sensitive to hot or cold?.....___Yes ___No
Are you teeth sensitive to sweets?.....___Yes ___No
Are your teeth sensitive to biting or chewing?.....___Yes ___No

How often do you floss your teeth? _____
Do you use mouthwash?.....___Yes ___No
Do you ever feel (or have you ever been told) that you don't have fresh breath?.....___Yes ___No

Have you ever been treated for periodontal disease(gum disease, gingivitis, pyorrhea, trench mouth)? ___Yes ___No
Do your gums bleed?.....___Yes ___No
Do your gums feel irritated, tender, or swollen?.....___Yes ___No

Does your mouth feel dry?.....___Yes ___No
Do you have a burning sensation on your lips or tongue?.....___Yes ___No
Do you use tobacco products?.....___Yes ___No
If you smoke, how many packs per day?.....

Have you had surgery for a tumor, growth or other condition of your mouth or lips?.....___Yes ___No
Have you ever had any chemotherapy or radiation treatments?.....___Yes ___No
If yes, where?_____

Have you ever had a skin reaction to jewelry? ?.....___Yes ___No

Are you delighted with your smile?.....___Yes ___No
Please rate your smile from 1 to 10 (1= I hate it, 10= I love it):_____
If you had a magic wand, what if anything, would to change about your teeth and gums?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent, or Guardian_____