DENTAL TECHNOLOGY CENTER
OF HAWAII

1314 S. King St., Suite 724 Honolulu, Hi 96814
O: 291.2254 F: 596.2384 E: dtcofhawaii@outlook.com

Medical History

Please answer as best as you can. For any YES answers, please give brief explanation.

1. Are you under the care of a physician now? N __ Y __ Exp: _____
2. Have you ever been hospitalized or had a major operation? N __ Y __
   Exp: _____
3. Have you ever had a serious head or neck injury? N __ Y __ Exp: _____
4. Are you taking medications, pills, or drugs? N __ Y __ Exp: _____
5. Do you take or have you taken Phen-Fen or Redux N __ Y __ Exp: _____
6. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? N __ Y __ Exp: _____
7. Are you on a special diet? N __ Y __ Exp: _____
8. Do you use smoke, chew, vape, or drink alcohol? N __ Y __ Exp: _____
9. Do you use controlled substances? N __ Y __ Exp: _____
10. Women Only:
    Are you pregnant/trying to get pregnant? N __ Y __

11. Do you have, or have you had, any of the following? (Please check all that applies)

AIDS/HIV Positive ___ Alzheimer's Disease ___ Anaphylaxis ___ Anemia ___ Angina __

Arthritis/Gout __ Artificial Heart Valve __ Artificial Joint __ Asthma __ Blood Disease __

Blood Transfusion __ Breathing Problems __ Bruise Easily __ Cancer __ (Type of Cancer)
_____

Chemotherapy __ Chest Pains __ Cold Sores/Fever Blisters __ Congenital Heart Disorder __

Convulsions __ Cortisone Medicines __ Diabetes __ Drug Addiction __ Easily Winded __

Emphysema __ Epilepsy or Seizures __ Excessive Bleeding __ Excessive Thirst __

Fainting Spells/Dizziness __ Frequent Cough __ Frequent Diarrhea __ Frequent Headaches __

Genital Herpes __ Glaucoma __ Hay Fever __ Heart Attack/Failure __ Heart Murmur __

Pacemaker __ Heart Trouble/Disease __ Hemophilia __ Hepatitis A __ Hepatitis B or C __

Herpes __ High Blood Pressure __ High Chloesterol __ Hives or Rash __ Hypoglycemia __

Irregular Heartbeat __ Kidney Problems __ Leukemia __ Liver Disease __

Mitral Valve Prolapse __ Osteoporosis __ Pain in Jaw Joints __ Parathyroid Disease __

DENTAL TECHNOLOGY CENTER
OF HAWAII

1314 S. King St., Suite 724 Honolulu, Hi 96814
O: 291.2254 F: 596.2384 E: dtcofhawaii@outlook.com

Psychiatric Care __ Radiation Treatment __ Recent Weight Loss __ Renal Dialysis __

Rheumatic Fever __ Rheumatism __ Scarlet Fever __ Shingles __ Sickle Cell Disease __

Sinus Trouble __ Spina Bifida __ Stomach/Intestinal Disease __ Stroke __

Swelling of Limbs __ Thyroid Disease __ Tonsillitis __ Tuberculosis __ Tumors or Growths __

Ulcers __ Veneral Disease __ Yellow Jaundice __

12. Have you ever had any other serious illness not listed above? N __ Y __ Exp: _____
_____

13. Are you experiencing any pain right now? N __ Y __ If yes, approximately how long have you had this pain? _____

14. Is the pain you are experiencing associated with hot and cold temperature? (i.e.: hot or cold food or beverages) N __ Y __ Exp: _____

15. Is the pain you are experiencing associated with pressure? (i.e.: chewing, biting) N __ Y __ Exp:
_____

16. Does the pain you are experiencing come and go or is it consistent? Exp: _____
_____

17. Have you been seen by your Dentist or your Primary Care Physician for this concern?
N __ Y __ If Yes, when: _____ If Yes, what was recommended and /or prescribed to you? _____

18. Do you remember doing anything that could have caused the onset of this pain? (i.e.: possibly bit into something, ate something hot/spicy, recently experienced a sinus infection/cold etc.)
N __ Y __ Exp: _____

19. Have you noticed any bleeding or fluid drainage? N __ Y __ Exp: _____

20. Is there anything else we should know, not listed above? N __ Y __ Exp: _____
_____

Thank You for taking the time in filling out your medical history as best as you can.