Dr. Kellen Tadano DDS, P.C.
FAMILY/COSMETIC DENTISTRY

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Please fill in the form, print it out, and bring to your first appointment.

Medical History

Today's Date: _____ Date of Last Dental Visit: _____

Reason for today's visit: _____

Current medications you are taking: _____

Have you ever had any of the following?

Yes	No		Yes	No		Yes	No	
○	○	AIDS	○	○	Alzheimer's Disease	○	○	Anemia
○	○	Arthritis	○	○	Artificial Joints/Hips	○	○	Artificial Heart Valve
○	○	Asthma	○	○	Blood Disease	○	○	Blood Transfusion
○	○	Bruise Easily	○	○	Cancer	○	○	Chemotherapy/Radiation
○	○	Chest Pain	○	○	Cold Sores	○	○	Cortisone Medicine
○	○	Diabetes	○	○	Dizziness	○	○	Drug Addiction
○	○	Emphysema	○	○	Epilepsy or Seizures	○	○	Excessive Bleeding
○	○	Excessive Thirst	○	○	Fainting	○	○	Fever Blisters
○	○	Frequent Cough	○	○	Glaucoma	○	○	Growths
○	○	Hay Fever	○	○	Head Injuries	○	○	Heart Disease
○	○	Heart Lesion	○	○	Heart Trouble	○	○	Heart Murmur
○	○	Heart Surgery	○	○	Hemophilia	○	○	Hepatitis A / B
○	○	Herpes	○	○	High Blood Pressure	○	○	Low Blood Pressure
○	○	Hypoglycemia	○	○	Jaundice	○	○	Kidney Disease
○	○	Liver Disease	○	○	Lung Disease	○	○	Mental Disorders
○	○	Mitral Valve Prolapse	○	○	Nervous Disorders	○	○	Pacemaker
○	○	Pain in Jaw Joints	○	○	Psychiatric Care	○	○	Radiation Treatment
○	○	Recent Weight Loss	○	○	Respiratory Problems	○	○	Rheumatic Fever
○	○	Rheumatism	○	○	Scarlet Fever	○	○	Shortness of Breath
○	○	Sickle Cell Anemia	○	○	Sinus Problems	○	○	Stomach Problems
○	○	Stroke	○	○	Swelling of Extremities	○	○	Thyroid Disease
○	○	Tuberculosis	○	○	Tumors	○	○	Ulcers
○	○	Venereal Disease	○	○	Cobalt Treatment	○	○	Yellow Jaundice

Are you allergic to any of the following?

☐ Penicillin ☐ Latex ☐ Sulfa Drugs ☐ Ibuprofen ☐ Tetracycline ☐ Aspirin ☐ Codeine ☐ Epinephrine
☐ Other, Please List: _____

Have you ever taken Phen-Phen/Redux? ○ Yes ○ No

For Women: Are you pregnant? ○ Yes ○ No If yes, due date: _____
Note to Women: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician or gynecologist for assistance regarding additional or alternative methods of birth control.

Have you ever had any complications following dental treatment? ○ Yes ○ No
If yes, please explain: _____

Have you been admitted to a hospital or needed emergency care during the past two years? ○ Yes ○ No
If yes, please explain: _____

Are you now under the care of a physician? ○ Yes ○ No
If yes, please explain and provide physician name & phone: _____

In case of emergency, whom to contact: _____ **Phone #**: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctors at the next appointment without fail.

_____ _____ _____
Signature of Responsible Party, Parent or Guardian | Print Name | Date