Christine H Choe, D.D.S.
Areté Dental

Patient Medical History

Today's Date: ____/____/____

Patient Name: ______________________ Date of Birth: ____/____/____ Sex: ________

Home Address: ______________________ Home Phone: ________

______________________ Cell Phone: ________

Email: ______________________ Referral: ________

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 may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Physician 주치의: ______________________

Physician Contact 주치의 전화번호: ______________________

Date of Last Exam 마지막 검사 날짜: ______________________

	YES	NO
Are you under medical treatment now? 현재 치료를 받고 계십니까?	☐	☐
Have you ever been hospitalized or had a major operation? 입원이나 큰수술을 하신적이 있습니까?	☐	☐
Are you taking any medications, pills, or drugs? 복용하고 있는 처방약이 있습니까? ______________	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Fosamax, Boniva, Actonel 같은 비스포스포네이트가 함유된 (골다골증약)을 복용한적이 있습니까?	☐	☐

	YES	NO
Do you use tobacco? 담배를 피우십니까?	☐	☐
Do you use controlled substances? 규제약물을 하십니까?	☐	☐

Are you allergic to any of the following? 다음과 같은 알러지가 있습니까?

YES	NO		YES	NO		YES	NO	
☐	☐	Aspirin 아스피린	☐	☐	Penicillin 페니실린	☐	☐	Codeine 코데인
☐	☐	Acrylic 아크릴	☐	☐	Metal 금속	☐	☐	Latex 라텍스
☐	☐	Sulfa Drugs 설파제	☐	☐	Local Anesthetics 국소마취제			
☐	☐	Others 그외: ______________						

Women Only: 여성이시면:	YES	NO
Pregnant/Trying to get pregnant? 임신중/임신 계획중이십니까?	☐	☐
Nursing? 모유 수유중 이십니까?	☐	☐
Taking oral contraceptives? 경구 피임약을 복용중이십니까?	☐	☐

Do you have, or have you had, any of the following? 다음과 같은질환을 앓고 있거나 앓은 적이 있습니까?

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS/HIV Positive 에이즈/HIV 양성	☐	☐	Fainting Spells/Dizziness 졸도/어지러움증	☐	☐	Osteoporosis 골다공증
☐	☐	Alzheimer's Disease 알츠하이머	☐	☐	Glaucoma 녹내장	☐	☐	Parathyroid Disease 부갑산병
☐	☐	Anaphylaxis 알러지 과민쇼크	☐	☐	Hay Fever 건초열	☐	☐	Prostate Gland Enlarged 전립선 비대증
☐	☐	Anemia 빈혈증	☐	☐	Heart Attack/Failure 심장마비	☐	☐	Psychiatric Care 정신질환
☐	☐	Angina 협심증	☐	☐	Heart Murmur 심잡음	☐	☐	Radiation Treatments 방사선 치료
☐	☐	Arrhythmia/Irregular Heartbeat 부정맥	☐	☐	Heart Pacemaker 인공심박기	☐	☐	Recent Weight Loss 체중급감소
☐	☐	Arthritis/Gout 관절염	☐	☐	Heart Trouble/Disease 심장질환	☐	☐	Renal Dialysis 신장 인공투석
☐	☐	Artificial Joint 인공관절	☐	☐	Hepatitis A A형간염	☐	☐	Respitory Disease 기관지 질환
☐	☐	Asthma 천식	☐	☐	Hepatitis B or C B/C형간염	☐	☐	Rheumatism 류머티즈
☐	☐	Blood Disease 혈액질환	☐	☐	Herpes 헤르페즈	☐	☐	Shingles 대상포진
☐	☐	Cancer 암	☐	☐	High Blood Pressure 고혈압	☐	☐	Sickle Cell Disease 용혈빈혈
☐	☐	Cataract 백내장	☐	☐	High Cholesterol 고콜레스테롤	☐	☐	Stomach/Intestinal Disease 위/장질환
☐	☐	Chemotherapy 항암치료	☐	☐	Hives or Rash 두드러기/가려움증	☐	☐	Stroke 뇌졸증
☐	☐	Chest Pains 가슴통증	☐	☐	Hypoglycemia 저혈당증	☐	☐	Thyroid Disease 갑상선 질환
☐	☐	Convulsions 경련	☐	☐	Kidney Problems 신장질환	☐	☐	Tonsillitis 편도염
☐	☐	Diabetes 당뇨	☐	☐	Leukemia 백혈병	☐	☐	Tuberculosis 결핵
☐	☐	Drug Addiction 약물중독	☐	☐	Liver Disease 간질환	☐	☐	Tumors or Growths 종양
☐	☐	Emphysema 폐기종	☐	☐	Low Blood Pressure 저혈압	☐	☐	Ulcers 궤양
☐	☐	Epilepsy or Seizures 뇌전증/간질	☐	☐	Lung Disease 폐질환	☐	☐	Venereal Disease 성병
☐	☐	Excessive Bleeding 과다출혈	☐	☐	Mitral Valve Prolapse 승모판막탈출증			

Have you ever had any serious illness not listed above?
위에 명시되지 않은 질환이 있습니까? ______________________

Comments: ______________________

______________________ Dentist Signature: ____________ Date: ____________

I hereby certify that I have read and understood the above information and the questions have been accurately answered to the best of my knowledge. I understand that providing incorrect information can put my health at risk. X-Rays: Unless otherwise indicated, I hereby give my consent to take x-rays and my x-rays to be used as case presentations. By declining to take x-rays, I understand the risk of being mistreated and hinder in making accurate diagnosis. Also, in refusing the recommended x-rays, I take full responsibility of any undiagnosed interproximal cavities, any undiagnosed tumors, cysts, or abscessed teeth found in oral cavity, and bone loss which may be noted on the dental x-rays.

Patient, Parent or Guardian Signature: 환자,부모, 보호자 서명:

X ______________________ Date: ____________