Cupertino Dental and Facial Esthetics
10413 Torre Avenue Ste., 600
Cupertino, CA 95014
408.865.1777
www.smilegallery.com

MEDICAL HISTORY FORM

Name_____
First Last

Date of Birth _____/_____ /_____

Street Address:

_____

City:_____State:_____ Zip_____

Home Phone: ( )_____-_____ Cell Phone: ( )_____-_____

Business Phone: ( )_____-_____

Email:_____

May we contact you via email for specials and office announcements (please circle)? YES NO

Emergency Contact: _____ Relationship:_____

Phone: ( ) _____-_____

How Did You Hear About Us?

_____

Medical History

1. Reason for Consultation/ Visit?

_____

2. List All Medications You Are Currently Taking (Include Anything Used in the Past Six Months. i.e. Accutane)

_____

3. List All Skin Care Products You Are Currently Using (Include Anything Used in the Past Six Months. i.e. Retina A, Glycolic Acid, etc.)

_____

4. Are You Tanning? (Sun or Tanning Bed) Yes No

5. Are You Pregnant? Yes No

6. Are You Breastfeeding? Yes No

7. Have You Been Treated For (Circle All That Apply):

Acne Depression Skin Disease Cold Sores Diabetes

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8. List Any Allergies You May Have (Include soaps, cleansers, nuts, cinnamon, lavender, latex etc.)_____

9. Have You Been Told To Pre-Medicate For Dental Procedures, If So Why?

_____

10. Do You Have Or Have You Ever Had Any Of The Following Conditions?

__Abnormal Heart Conditions __Heart Murmurs __High Blood Pressure __Hepatitis __Bell's Palsy/Facial Paralysis __Mitral Valve Prolapse __Low Blood Pressure __High Blood Pressure __Lidocaine Allergy __Latex Allergy __Kidney Problems __Thyroid Disease__Prolonged Bleeding Time __Circulatory Problems __Fainting Spells __Cold Sores __Liver Problems __Rheumatic Fever __Asthma __Other (please describe below)

If yes with any, please describe _____

Please mark all services that are of interest to you now or in the future:

□General Dentistry	□Botox®	□Zoom® Teeth Whitening	
□Cosmetic Dentistry	□Fillers	□Routine Care (cleaning and exam)	
□Porcelain Veneers	□Facial Fat Reduction	□Dental Implants	
□Gum Correction	□Oral Maxillofacial Surgery	□Skincare	
□HydraFacialMD®	□TMJ Correction	□Invisalign	□Tooth Extractions

Are you interested in dermal fillers or Botox® treatments to treat:	**Yes**	**No**
Gummy smile	□	□
TMJ	□	□
Hyperhydrosis (excessive sweating of underarms, hands, feet)	□	□
Fine lines and wrinkles (crows feet, frown lines)	□	□
Lip enhancement	□	□
Fillers in the cheeks for collagen deficit	□	□
Contouring the cheeks	□	□

Are there any other dental or facial aesthetic treatments that you would like us to know about?
□Yes □No
If yes, please describe _____

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Dental History (If applicable)

How often do you brush your teeth? _____ How often do you floss?_____

Do you have any current dental problems? □ Yes □ No

If yes, please describe: _____

Are any of your teeth sensitive to:	YES	NO
Hot or cold?	□	□
Sweets?	□	□
Biting or chewing?	□	□
Have you noticed a bad taste or bad breath?	□	□
Do you get cold sores, blisters, oral lesions?	□	□
Do your gums bleed or hurt?	□	□
Anyone in your family have gum disease?	□	□
Any loose teeth or a change in your bite?	□	□
Does food get stuck in your teeth?	□	□
Do you:	□	□
Clench or grind your teeth?	□	□
Bite your lips or cheek?		
Hold objects with your teeth?	□	□
Mouth breathe while awake/sleep?	□	□
Have tired jaws?	□	□
Smoke/chew tobacco?	□	□
Use recreational drugs?	□	□
Drink alcohol?	□	□

Have you ever had:	Yes	No
Orthodontic treatment?	□	□
Oral surgery?	□	□
Periodontal treatment?	□	□
Bite adjusted?	□	□
Bite plate or mouth guard?	□	□
Serious injury to mouth or head?	□	□
Have you experienced?		
Clicking or popping of the jaw?	□	□
Pain? (joing, ear, side or face)	□	□
Difficulty opening or closing mouth?	□	□
Difficulty chewing?	□	□
Headaches, neckaches	□	□
Sore muscles?	□	□
Are you happy with your smile?	□	□
Would you like straighter teeth?	□	□
Whiter teeth?	□	□
Do you want to keep all your teeth?	□	□
Do you feel nervous about dental Treatment?	□	□

I certify that the information I have given above is true and accurate to the best of my knowledge. I know of no medical conditions that I have not disclosed to the medical staff of Cupertino Dental and Facial Esthetics

Signature: _____ Date: _____

Print Name: _____

Physician/ Practitioner Signature: _____ Date: _____