ELLIS WONG DDS INC.

Today's Date: _____

Confidential Health History

Personal Information

Full Name: _____
Last *First* *M.I.* *I prefer to be called*

Birth Date (MM/DD/YYYY): _____ / _____ / _____ Age: _____ ☐ Male ☐ Female

Circle the Appropriate Answer (Leave it blank if you do not understand the question.)

1. Yes No Is your general health good?
   If ***No***, please explain: _____
2. Yes No Has there been a change in your health within the last year?
   If ***Yes***, please explain: _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last 3 years?
   If ***Yes***, please explain: _____
4. Yes No Are you being treated by a physician now?
   If ***Yes***, please explain: _____
   Date of last medical exam? _____ Reason for exam: _____
5. Yes No Have you had problems with prior dental treatment?
   If ***Yes***, please explain: _____
   Date of last dental exam? _____ Name of last treating dentist: _____
6. Yes No Are you in pain now?
   If ***Yes***, please explain: _____

Have you experienced any of the following? (Please circle "Y" for Yes or "N" for No.)

Y	**N**	Bleeding problems	**Y**	**N**	Difficulty urinating	**Y**	**N**	Jaundice
Y	**N**	Blood in stools	**Y**	**N**	Dizziness	**Y**	**N**	Joint pain or stiffness
Y	**N**	Blood in urine	**Y**	**N**	Dry mouth	**Y**	**N**	Night sweats
Y	**N**	Blurred vision	**Y**	**N**	Excessive thirst	**Y**	**N**	Persistent cough
Y	**N**	Bruise easily	**Y**	**N**	Fainting spells	**Y**	**N**	Recent significant weight loss
Y	**N**	Chest pain (angina)	**Y**	**N**	Fever	**Y**	**N**	Ringing in ears
Y	**N**	Coughing up blood	**Y**	**N**	Frequent urination	**Y**	**N**	Shortness of breath
Y	**N**	Diarrhea or constipation	**Y**	**N**	Frequent vomiting	**Y**	**N**	Sinus problems
Y	**N**	Difficulty swallowing	**Y**	**N**	Headaches	**Y**	**N**	Swollen ankles

Have you had or do you have any of the following? (Please circle "Y" for Yes or "N" for No.)

Y	**N**	Bleeding problems	**Y**	**N**	Family history of diabetes	**Y**	**N**	Osteoporosis
Y	**N**	AIDS/HIV	**Y**	**N**	Family history of heart	**Y**	**N**	Psychiatric care
Y	**N**	Anemia			disease	**Y**	**N**	Radiation
Y	**N**	Arthritis, rheumatism	**Y**	**N**	Hardening of arteries	**Y**	**N**	Rheumatic fever
Y	**N**	Artificial joint	**Y**	**N**	Heart attack	**Y**	**N**	Seizures
Y	**N**	Asthma	**Y**	**N**	Heart defects	**Y**	**N**	Sexual transmitted disease
Y	**N**	Canker or cold sores	**Y**	**N**	Heart disease	**Y**	**N**	Skin disease
Y	**N**	Chemotherapy	**Y**	**N**	Heart murmurs	**Y**	**N**	Stomach problems or ulcers
Y	**N**	Cosmetic surgery	**Y**	**N**	Hepatitis	**Y**	**N**	Stroke
Y	**N**	Diabetes	**Y**	**N**	Herpes	**Y**	**N**	Surgeries
Y	**N**	Eating disorders	**Y**	**N**	High blood pressure	**Y**	**N**	Thyroid disease
Y	**N**	Emphysema or other lung	**Y**	**N**	Hospitalization	**Y**	**N**	Transplants
		disease	**Y**	**N**	Kidney or bladder disease	**Y**	**N**	Tuberculosis
Y	**N**	Eye disease	**Y**	**N**	Liver disease	**Y**	**N**	Tumors or cancer

607 North Larchmont Boulevard | Los Angeles, California 90004
Phone (323) 464-5555 | Fax (323) 464-3075

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Are you allergic to or have you had a reaction to any of the following? (Please circle "Y" for Yes or "N" for No.)

Y	**N**	Aspirin	**Y**	**N**	Latex	**Y**	**N**	Penicillin
Y	**N**	Codeine	**Y**	**N**	Local anesthetic (Novacaine	**Y**	**N**	Percodan
Y	**N**	Darvon			or Xylocaine)	**Y**	**N**	Tetracycline
Y	**N**	Demerol	**Y**	**N**	Metal	**Y**	**N**	Valium
Y	**N**	Erythromycin	**Y**	**N**	Nitrous oxide	**Y**	**N**	Vicodin

Y **N** Others: _____

Are you taking or have you taken any of the following in the last three months? (Please circle "Y" for Yes or "N" for No.)

Y	**N**	Alcohol	**Y**	**N**	Bisphosphonate (Fosamax)	**Y**	**N**	Supplements
Y	**N**	Antibiotics	**Y**	**N**	Over-the-counter medicines	**Y**	**N**	Tobacco in any form
Y	**N**	Aspirin	**Y**	**N**	Recreational drugs	**Y**	**N**	Weight loss medications

Please List ***ALL*** medicines you are currently taking: _____

WOMEN ONLY (Please circle Yes or No.)

1. Yes No Are you or could you be pregnant?
   If ***Yes***, what month: _____
2. Yes No Are you nursing?
3. Yes No Are you taking birth control pills?

ALL PATIENTS (Please circle Yes or No.)

1. Yes No Do you have or have you had any other disease or medical problems NOT listed on on this form?
   If ***Yes***, please explain: _____
2. Yes No Have you ever been pre-medicated for dental treatment?
   If ***Yes***, please explain: _____
3. Yes No Have you ever taken Fen-phen?
   If ***Yes***, please explain: _____
4. Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Signature: _____ ***Date:*** _____ ***Relationship to Patient:*** _____

Physician's Name: _____ ***Phone Number:*** _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ ***Date:*** _____ ***Relationship to Patient:*** _____

Signature of Dentist: _____ ***Date:*** _____

MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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