PATIENT HEALTH HISTORY
(CONFIDENTIAL)

Today's Date_____/_____/_____

Name _____ Birth Date _____/_____/_____

Age_____ Sex M F Weight _____ Height _____ Treating Dentist _____

Address _____

City _____ State ____ Zip _____ Email _____

Home Phone _____ Social Security # _____/_____/_____

Name of Person Responsible for the Account _____

Relationship to Patient _____

Birth Date _____/_____/_____ Home Phone _____ Cell phone _____

Address _____

City _____ State_____ Zip _____

Employer _____ Social Security # _____/_____/_____

Have you ever had any of the following medical problems (Please check **all** boxes that apply)

Yes	No		Yes	No	
☐	☐	Allergies to any Drugs / Foods	☐	☐	Diabetes: Type I II
☐	☐	Any Hospital Stays (Over Night)	☐	☐	Seizures / Epilepsy
☐	☐	Any Operation / Surgery	☐	☐	Handicaps / Disabilities
☐	☐	Heart Disease	☐	☐	Cerebral Palsy
☐	☐	Asthma / Lung Problems	☐	☐	Developmentally Delayed
☐	☐	Hepatitis A B C / Liver Problems	☐	☐	Rheumatic / Scarlet Fever
☐	☐	Kidney Problems	☐	☐	Cancer
☐	☐	Bleeding Problems	☐	☐	Hearing / Visual Impairments
☐	☐	Heart Murmurs / Heart Defects	☐	☐	Tuberculosis
☐	☐	Smoke / Exposed to Tobacco smoke	☐	☐	Wear Contact Lenses

☐ ☐ Have you ever taken any **diet** pills/supplements in the past or currently?

☐ ☐ **WOMEN**: Is there any possibility that you could be **pregnant**?

Please comment on medical condition(s) **listed / not listed** above that you have / had:

_____

_____

_____

List of all current **medications**

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List all **allergies** including medications **Latex Allergy** ☐ Yes ☐ No

1. _____ 3. _____
2. _____ 4. _____

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Currently under the care of a physician? ☐ Yes ☐ No Date of Last Visit _____

Physician Name_____ Phone Number _____

Specialist Name_____ Phone Number _____

Specialist Name_____ Phone Number _____

Please describe your current physical health status: ☐ Excellent ☐ Fair ☐ Poor

The information on this questionnaire is accurate to the best of my knowledge. I understand that the information will be held in the strictest of confidence and it is my responsibility to inform Dr. Sophia Tan, DDS of any changes in my medical status at the earliest possible time.

_____ _____/_____/_____
Print Patient Name Date

_____
Signature of Patient/Parent or Legal Guardian

_____ _____ _____
Reviewed by: Dr. Sophia Tan, DDS Date Time