TYSON
FAMILY DENTAL

CHILD HEALTH HISTORY

Patient Name: _____ Date of Birth: _____ □ Male □ Female

Parent/Guardian Name: _____ Home/ Cell #: _____

Address: _____ City _____ State _____ Zip code _____

Email: _____Emergency Contact_____

How would you describe your child's current health? □ Excellent □ Good □ Fair □ Poor

List your child's current physician:

Name_____ Type:_____ How Long?_____

Date of last physical exam_____ Purpose:_____

Are you aware of any changes in your child's general health in the last year?	□ Yes	□ No
Has your child been hospitalized for illness or surgery in the past year?	□ Yes	□ No
Has your child been under a medical doctor's care during the past year?	□ Yes	□ No
Has your ever had excessive bleeding that required special treatment?	□ Yes	□ No
Is your child on a special or restricted diet of any kind?	□ Yes	□ No

Other_____

_____

Indicate which of the following your child has had or has presently. Check **Yes** or **No** to each item:

	YES	NO		YES	NO		YES	NO
Latex Allergy			Shortness of breathe			Sinus Troubles		
Heart Trouble			Ankle Swell			Allergies or Hives		
Heart Disease or Attack			Anemia			Diabetes		
Angina			Sickle Cell Disease			Stroke		
High Blood Pressure			Artificial Joint(Hip/Knee)			Frequent thirst and/or Urination		
Heart Murmur			Kidney, Bladder Trouble			Epilepsy or Seizures		
Rheumatic Fever			Thyroid Disease			Frequent Headaches		
Congenital Heart Lesions			Emphysema			Fainting or Dizzy Spells		
Artificial Heart Valve			Persistent Cough			Psychiatric care		
Scarlet Fever			Tuberculosis			Cancers or Tumors		
Heart Pacemaker			Asthma			Radiation Treatment		
Heart Surgery			Hay Fever			Chemotherapy		
Arthritis/Rheumatism			Glaucoma			Hepatitis		
Liver Disease			Jaundice			AIDS		
Blood Transfusion			Drug or Alcohol Addiction			Unintentional Weight		

Please check any medications your child is/are allergic to:

□ Penicillin □ Erythromycin □ Carbocaine □ Xylocaine □Tylenol □Aspirin □Anesthetics □ Codeine

Others: _____

List all medications you are currently taking:

	Name of Medication/Dosage		Name of Medication/Dosage
1.		4.	
2.		5.	
3.		6.	

Do you have any medical conditions/diseases not listed above we should know about? □ Yes □ No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or if my medications change, I will inform the doctor on or before my next appointment without fail.

_____ _____

Parent/Guardian Signature Date Doctors Signature Date