TYSON
FAMILY DENTAL

# PATIENT HEALTH HISTORY

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

□ Self □ Child – Guardian _____ Home/ Cell #: _____

Address: _____ City _____ State _____ Zip code _____

Email: _____

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

List your current physicians:

Name_____ Type:_____ How Long?_____

Date of last physical exam_____ Purpose:_____

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

Do you smoke? □ Yes □ No How Much?_____ How long?_____

Do you use smokeless tobacco? □ Yes □ No How much? _____ How long?_____

Indicate which of the following you have had or have at present. 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 you 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.*

_____ _____

Patient/Guardian Signature Date Doctors Signature Date