PATIENT HEALTH RECORD

GIBBS M. PREVOST, JR., D.D.S. • 4717 Papermill Rd • Knoxville, TN 37909

To help us render the proper dental services to you, please be kind enough to answer the following questions. Thank you.

DATE: _____ NAME: _____ PHONE: _____
(LAST) (MIDDLE) (FIRST)

DATE OF BIRTH: _____ SEX: ____ HEIGHT: _____ WEIGHT: _____ OCCUPATION: _____

1. How is your general health? ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

2. Name and Address of Physician: _____

3. Last Complete Physical? _____

4. Please list all medications and dosages you are now taking. _____

5. Do you have any prosthetic joints (artificial hip, knee, etc.)? _____

6. Please check the appropriate boxes:

Have you had a blood transfusion? ☐ YES ☐ NO

Do you have immune (defense) system problems? ☐ YES ☐ NO
Please describe: _____

Can you donate blood? ☐ YES ☐ NO
If not, why not? _____

Are you pregnant? ☐ YES ☐ NO
How long? _____

Do you wear a heart pacemaker? ☐ YES ☐ NO

Have you ever been treated with x-ray, other than diagnostically? ☐ YES ☐ NO

Do you have excessive thirst and/or urination? ☐ YES ☐ NO

Are you subject to fainting spells? ☐ YES ☐ NO

Do you use any form of tobacco? ☐ YES ☐ NO

Have you lost or gained significant amounts of weight in the last year? ☐ YES ☐ NO

Have you been tested for AIDS? ☐ YES ☐ NO

Are you subject to prolonged bleeding? ☐ YES ☐ NO

7. Are you allergic to any medication? _____
☐ PENICILLIN ☐ CODEINE ☐ LOCAL INJECTED ANESTHETICS ☐ LATEX

8. Have you ever been treated for:

AIDS	☐ YES ☐ NO	Congenital Heart Lesions	☐ YES ☐ NO	Heart Disease	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Abnormal Blood Pressure	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO
Artificlal Joint	☐ YES ☐ NO	Tuberculosis or Lung Disease	☐ YES ☐ NO	Any Blood Disease	☐ YES ☐ NO
Cough	☐ YES ☐ NO	Pacemaker	☐ YES ☐ NO	Cancer	☐ YES ☐ NO
Stroke	☐ YES ☐ NO	ARC (AIDS-Related Complex)	☐ YES ☐ NO	Heart Murmur	☐ YES ☐ NO
Kidney Problems	☐ YES ☐ NO	Artificial Heart Valve	☐ YES ☐ NO	Thyroid Disease	☐ YES ☐ NO
Ulcers	☐ YES ☐ NO	Stomach or Intestinal Disease	☐ YES ☐ NO	Jaundice	☐ YES ☐ NO
Epilepsy	☐ YES ☐ NO	Asthma or Hay Fever	☐ YES ☐ NO	Sinus Trouble	☐ YES ☐ NO
Irregular Heartbeat	☐ YES ☐ NO	Mitral Valve Prolapse	☐ YES ☐ NO	Heart Attack/Failure	☐ YES ☐ NO
Arthritis	☐ YES ☐ NO	Any Liver Disease	☐ YES ☐ NO	Glaucoma	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Respiratory Disease (C.O.P.D.)	☐ YES ☐ NO	Hepatitis	☐ A ☐ B ☐ C

9. What is your blood pressure? _____

10. Please list all major surgeries or operations you have had. _____

I hereby certify that the health information given on this form is complete and correct to the best of my knowledge.

Signature: _____ Date: _____

Witness: _____ Date: _____

LEAVE THE FOLLOWING STATEMENT UNSIGNED WHEN FIRST COMPLETING THE FORM.

I certify that the updated information on this form is complete and correct.

Signature: _____ Date: _____

Witness: _____ Date: _____