SOUTHWEST GEORGIA PERIODONTICS
Medical History Form

Medical Physician's Name _____

Last Physical Exam _____

1. Are you having pain or discomfort at this time? ..... YES NO
2. Do you feel very nervous about having dental treatment? ..... YES NO
3. Have you ever had an unpleasant experience in the dental office? ..... YES NO
4. Have you been a patient in the hospital during the past two years? ..... YES NO
   If so, why? _____
5. Have you been under the care of a medical doctor during the past two years? ..... YES NO
6. Have you taken any medicine or drugs during the past two years? ..... YES NO
7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by penicillin, aspirin, codeine, or any drugs or medications, either prescription or over the counter? ..... YES NO
8. Have you or any immediate family members ever had any excessive bleeding or infection following a dental procedure? ..... YES NO
9. Circle any of the following which you have had or have at present:

Heart Failure	Emphysema	HIV/AIDS
Heart Disease or Attack	Cough	Hepatitis A (infectious)
Angina Pectoris (Chest Pain)	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Liver Disease
Heart Murmur	Hay Fever	Yellow Jaundice
Rheumatic Fever	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease (Syphilis,Gonorrhea)
Heart Pacemaker	Radiation or Cobalt Treatment	Cold Sores
Heart By-Pass Surgery	Chemotherapy (Cancer, Leukemia)	Genital Herpes
Artificial Joint	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizzy Spells
Stroke	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
		Bruise Easily

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than 2 pillows to sleep (to help with breathing)? ..... YES NO
13. Have you lost or gained more that 10 pounds in the past year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Has your medical doctor ever said you have a cancer tumor? ..... YES NO
17. Do you have any disease, condition, or problem not listed? ..... YES NO
18. WOMEN: Are you pregnant now? ..... YES NO
    Are you practicing birth control? ..... YES NO
    Do you anticipate becoming pregnant? ..... YES NO
19. Do you smoke? If yes, How much? ..... YES NO

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

_____	_____	_____
Date	Signature	Signature of Patient, Parent or Guardian