Kennestone Periodontics, PC HEALTH HISTORY

PHYSICIAN: _____ OFFICE PHONE: _____ DATE OF LAST PHYSICAL: _____

	YES	NO
Are You Under Medical Care Now?	☐	☐
Have You Had Any Major Operations?	☐	☐

If Yes, Explain:

CARDIOVASCULAR:		
Rheumatic Fever	☐	☐
Mitral Valve Prolapse	☐	☐
Heart Murmur	☐	☐
Congenital Heart Defect	☐	☐
Angina or Heart Attack	☐	☐
Stroke	☐	☐
Congestive Heart Failure	☐	☐
Heart Surgery or Pacemaker	☐	☐
High or Low Blood Pressure	☐	☐
RESPIRATORY:		
Asthma or Bronchitis	☐	☐
Emphysema	☐	☐
Hay Fever / Sinus Issues	☐	☐
Shortness of Breath	☐	☐
ENDOCRINE:		
Diabetes	☐	☐
High or Low Thyroid Disease	☐	☐
Parathyroid Disease	☐	☐
BLOOD:		
Anemia	☐	☐
Excessive Bleeding	☐	☐
TAKE BLOOD THINNER OR ASPIRIN	☐	☐
Leukemia	☐	☐
Blood Transfusion	☐	☐

	YES	NO
KIDNEY:		
Kidney Infection	☐	☐
Kidney Surgery	☐	☐
Dialysis	☐	☐
INFECTIOUS DISEASES:		
Hepatitis	☐	☐
Venereal Disease	☐	☐
Tuberculosis (TB)	☐	☐
HIV	☐	☐
Herpes / Recurrent Cold Sores	☐	☐
MISCELLANEOUS:		
Fainting	☐	☐
Liver Disease	☐	☐
Arthritis	☐	☐
Ulcers	☐	☐
Glaucoma	☐	☐
Cancer / Radiation / Chemotherapy	☐	☐
Bisphosphonates	☐	☐
Epilepsy / Seizures	☐	☐
Phychiatric Treatment	☐	☐
Do you smoke?	☐	☐
How Much?		
Do Your Ankles Swell?	☐	☐
Do You Sleep Inclined?	☐	☐

Are You Taking Any Medication? If Yes, What? _____

	YES	NO
Are You In Good health At This Time?	☐	☐
Have Any Wounds Healed Slowly, Do You Bruise Easily? Any Complications From Surgery?	☐	☐
Persistent Swollen Glands In Your Neck?	☐	☐
History of Fainting or Seizures?	☐	☐
Abnormal Bleeding or Require Blood Transfusion?	☐	☐
Joint Replacement Surgery or Implanted Devices?	☐	☐
Drug or Alcohol Abuse?	☐	☐
Persistent Diarrhea or Unusual Weight Loss?	☐	☐
Allergies to Medicines?	☐	☐
Local or General Anesthesia?	☐	☐
Penicillin or other Antibiotics?	☐	☐
Aspirin Codeine	☐	☐
Iodine Barbiturates Sedatives or Sleeping Pills	☐	☐
Other Drugs Not Listed _____	☐	☐
Any Other Conditions NOT Listed that you feel your Doctor Should Know About? _____	☐	☐

WOMEN:

Are You Pregnant, May Be Pregnant, or Trying to Become Pregnant? If Yes, How Many Months? _____	☐	☐
Are You Nursing?	☐	☐
Are You Taking Birth Control Pills?	☐	☐

I certify that I have read and understand the above, I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I, the undersigned , have received a copy of this office's NOTICE OF PRIVACY PRACTICES.

Patient/Guardian Signature **Date**

Doctor's Signature **Date**