MEDICAL HISTORY

410 East McPherson Avenue ♦ Nashville, Georgia 31639 ♦ 229-686-7451 ♦ 229-686-7547 (fax)

CONFIDENTIAL -- PLEASE PRINT INFORMATION

Full Name_____Height_____Weight_____

Physician _____ Address_____ Phone_____

If you are completing this form for someone else, what is your relationship to him or her? _____

1. Have you been in a hospital during the past two years? ☐ Yes ☐ No
   If yes, please describe:_____
2. Have you been under the care of a physician within the last two years or are you now under the care of a physician?
   ☐ Yes ☐ No If yes, please describe:_____
3. Have you taken any drugs or medication within the last two years or are you now taking any? ☐ Yes ☐ No
   If so, why?_____
4. Are you allergic to or do you have trouble taking any drugs or medications? ☐ Yes ☐ No
   If yes, please list:_____
5. Have you had any bleeding problems which required special treatment? ☐ Yes ☐ No
   If yes, please describe:_____

6. Please indicate any of the following which you have had or have at the present time:

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

7. Has your medical doctor ever said that you have cancer or a tumor? ☐ Yes ☐ No
8. Do you have any disease, condition or problem no listed? ☐ Yes ☐ No
9. Women: Are you pregnant? ☐Yes ☐ No Do you anticipate becoming pregnant? ☐ Yes ☐ No

OVER

10. Do you have pain in your chest upon exertion? ☐ Yes ☐ No
11. Are you short of breath after mild exercise? ☐ Yes ☐ No
12. Do your ankles swell? ☐ Yes ☐ No
13. Do you get short of breath when you lie down? ☐ Yes ☐ No
14. Do you require extra pillows when you sleep? ☐ Yes ☐ No
15. Have you had any serious trouble associated with any previous dental treatment? ☐ Yes ☐ No

    If so, what? _____

16. Do you have any other health problems that you think I should know about? ☐ Yes ☐ No

    If yes, what? _____

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

Date _____ _____

Patient's Signature

_____

Assistant's Signature

Blood Pressure_____Pulse_____Date_____