

30. Are you taking any medications, drugs, pills regularly? _____ If so, list name and amount of dosage: _____

31. Are you being treated by a physician at this time? _____ If so, why? _____

32. Do you tire easily? _____ When? _____

33. List all childhood diseases: _____

34. Have you ever had, or do you now have, any of the following?
- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung trouble | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Gland trouble | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bladder trouble | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Clotting problems | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Ulcer(s) | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> Malignancy |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Bowel disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation therapy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> HIV Positive (AIDS) |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Other | <input type="checkbox"/> Heart Murmur |

Women: Are you pregnant? _____ Which month? _____ Oral contraceptives? _____

Have you reached menopause? _____ Are you taking hormones? _____

35. Have you ever taken cortisone? _____ When and for how long? _____

36. Have you taken anti-coagulants(blood thinner)? _____ When and for how long? _____

37. Circle, or note, the drug(s) you have reacted adversely to:

Penicillin	Aspirin	Codeine	Novocaine	Demerol
Antihistamines	Barbiturates	Local Anesthetics	Darvon	Antibiotics
Other _____				

38. Do you bruise easily? _____

39. Have you had major surgery? _____ When? _____ Any complications? _____
For what? _____

40. Are you on a special diet, to lose weight, low salt, diabetic, cholesterol, food allergy? _____

41. Have you gained _____ or lost _____ weight recently? How much? _____

42. Do you normally eat breakfast? _____ If so, what? _____

43. Do you take vitamins, mineral supplements? _____

44. Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your periodontal care: _____

In case of emergency, please contact:

Name _____ Business# _____ Home# _____

A photograph may be taken during your first visit to be placed in your file for identification, additional photographs may be taken for educational purposes. If taken they are of teeth and gums, no facial structures.

it's ok it is not ok

Signature of Patient _____ Date _____

Signature of Periodontist _____ Date _____
Macon M. Singletary, D.D.S., M.S.