Mitchel S. Godat, DDS, MS*
Grant T. King, DDS, MDS
*Board Certified Periodontist and Dental Implant Surgeon

Periodontal Associates
OF MEMPHIS
Periodontal, Laser and Dental Implant Therapy

Partners Emeritus
James R. Ross, D.D.S., M.S.*
Preston D. Miller, Jr., D.D.S.
Roger D. Craddock, D.D.S.

PATIENT MEDICAL HISTORY – PLEASE PRINT

PATIENT'S NAME			NAME OF GUARDIAN IF PATIENT IS UNDER 18:		
ADDRESS			TODAY'S DATE		DATE OF LAST PHYSICAL
CITY, STATE, ZIP			BIRTHDATE	SOCIAL SECURITY NO.	MARITAL STATUS
HOME PHONE	CELL PHONE	WORK PHONE	EMAIL		
PERSON PAYING IF DIFFERENT FROM PATIENT			PHONE #	EMAIL	
BILLING ADDRESS IF DIFFERENT FROM PATIENT					RELATIONSHIP TO PATIENT
MEDICAL PHYSICIAN NAME			MEDICAL PHYSICIAN PHONE #		
PREFERRED PHARMACY			PHARMACY PHONE #		

If Female, Please answer the following:

Y N
☐ ☐ Pregnant If Yes, # of Weeks _____
☐ ☐ Nursing
☐ ☐ Taking Birth Control Pills

Do you use Tobacco Products:

Y N
☐ ☐ Cigarettes/Pipe If Yes, # Per Day_____
☐ ☐ Vape
☐ ☐ Other _____

Height: _____ Weight: _____

MEDICAL CONDITIONS --- PLEASE SELECT YES OR NO IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

Y N
☐ ☐ Abnormal/Excessive Bleeding
☐ ☐ Acid Reflux/GERD
☐ ☐ ADD/ADHD
☐ ☐ AIDS
☐ ☐ Alcohol Use Disorder
☐ ☐ Anemia
☐ ☐ Angina Pectoris/Chest Pain
☐ ☐ Anxiety
☐ ☐ Arthritis (Rheumatoid/Osteo)
☐ ☐ Artificial Bones/Joints
☐ ☐ Asthma
☐ ☐ Autoimmune Disorder
☐ ☐ Blood Clots
☐ ☐ Blood Thinner
☐ ☐ Blood Transfusion
☐ ☐ Cancer
☐ ☐ Chemotherapy
☐ ☐ Colitis
☐ ☐ Congenital Heart Defect
☐ ☐ COPD/Emphysema
☐ ☐ Cosmetic Surgery
☐ ☐ Dental Anxiety
☐ ☐ Diabetes Type 1
☐ ☐ Diabetes Type 2
☐ ☐ Difficulty Breathing
☐ ☐ Drug Use Disorder
☐ ☐ Endocarditis
☐ ☐ Epilepsy
☐ ☐ Fainting Spell

Y N
☐ ☐ Fever Blisters
☐ ☐ Glaucoma
☐ ☐ Gout
☐ ☐ Headaches
☐ ☐ Heart Attack
☐ ☐ Heart Failure
☐ ☐ Heart Surgery
☐ ☐ Heart Valve Replacement
☐ ☐ Hemophilia
☐ ☐ Hepatitis A / E
☐ ☐ Hepatitis B / C / Other
☐ ☐ High Blood Pressure
☐ ☐ High Cholesterol
☐ ☐ HIV
☐ ☐ Irregular Heartbeat
☐ ☐ Kidney Problems
☐ ☐ Liver Disease
☐ ☐ Low Blood Pressure
☐ ☐ Mitral Valve Prolapse
☐ ☐ Organ Transplant
☐ ☐ Osteoporosis/ Osteopenia
☐ ☐ Pace Maker
☐ ☐ Psychiatric Problems
☐ ☐ Radiation Therapy
☐ ☐ Recreational Drug Use
☐ ☐ Respiratory Problems
☐ ☐ Rheumatic Fever
☐ ☐ Restless Leg Syndrome

Y N
☐ ☐ Seasonal Allergies/Hay Fever
☐ ☐ Seizures
☐ ☐ Shingles
☐ ☐ Sickle Cell Disease
☐ ☐ Sinus Problems
☐ ☐ Sleep Apnea
☐ ☐ Sexually Transmitted Disease
☐ ☐ Stroke
☐ ☐ Stomach Ulcer
☐ ☐ Thyroid (Hypo) Disease
☐ ☐ Thyroid (Hyper) Disease
☐ ☐ Tuberculosis
☐ ☐ Vertigo
☐ ☐ Xerostomia (Dry Mouth)

Y N Allergies/Adverse Reactions
☐ ☐ Aspirin
☐ ☐ Codeine
☐ ☐ Dental Anesthetics
☐ ☐ Erythromycin
☐ ☐ Jewelry/Metals
☐ ☐ Latex
☐ ☐ Penicillin
☐ ☐ Sedation Drugs
☐ ☐ Shellfish
☐ ☐ Tetracycline/Doxycycline
☐ ☐ Iodine/Betadine
☐ ☐ Other:
_____

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MEDICATIONS, HERBAL DRUGS, or VITAMINS	**QTY.**	**RX**	**O.T.C** ✓	**REASON:**
Please write "None" if you do not take any medication.				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please describe any disease, condition, or problem that you think this office should know about that has not already been listed:_____

_____

_____

EMERGENCY CONTACT:

Name:_____ Phone: _____

The information on my PATIENT MEDICAL HISTORY is correct and complete to the best of my knowledge. I authorize the release of any medical information by my physician(s) and dentist(s) as it pertains to my dental care.

I agree to any x-rays, photography, filming or recording of the procedure to be performed and I authorize release for teaching purposes/publications.

_____ _____
Signature of Patient or Legal Guardian Date