**Kevin M. Kirkland, D.M.D., P.C.**

Family Dentistry

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2023

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Last First Middle

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

**Name**

**Relationship**

**Phone**

Alt. Phone

State\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Best Contact Number?** Home Cell Work Other

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN CASE OF EMERGENCY, CONTACT**

**Name**  **Relationship**

**Phone**  **Alt. Phone**

Patient Birth date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Sex: M F Marital Status: Single Married Widowed Divorced

Patient SS# \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are completing this form for another person, what is your relationship to that person? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the following questions, circle **Yes** or **No**, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Has there been any change in your general health within the past year? ……………………... Yes No

 If so, please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Have you had any serious illness, operation, or been hospitalized in the past 5 years? ……….. Yes No

 If so, what was the illness or problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Are you having a specific dental problem? ……………………………………………………… Yes No

 Is so please explain

4. Are you under the care of a physician for a specific condition?.......................................................Yes No
 If yes, what condition is being treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Name and Number of your Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Date of last check up: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Continue on Back Side -**>**

2023

 6. **Are you allergic to or have you had a reaction to:**

Aspirin………………………………….. Yes No

Barbiturates, sedatives or sleeping pills… Yes No

Codeine or other narcotics……………… Yes No

Local anesthetics…………………….... Yes No

Latex……………………………………. Yes No

Penicillin or Other antibiotics…Yes No

Iodine........................................ Yes No

Sulfa drugs…………………… Yes No

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

7. **Do you have or have you had any of the following?**

Angina …………………. Yes No

Artificial heart valves … Yes No

Arteriosclerosis ………… Yes No

Cardiovascular disease … Yes No

Coronary insufficiency ... Yes No

Coronary occlusion …….. Yes No

Damaged heart valves … Yes No

Heart murmur …………. Yes No

Inborn heart defects …… Yes No

Heart trouble …………… Yes No

Mitral Valve Prolapse …. Yes No

Pacemaker …………….. Yes No

Rheumatic heart disease.. Yes No

Stroke ………………….. Yes No

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Sexually transmitted

 disease, herpes ………. Yes No

Shortness of breath …… Yes No

Sinus trouble …………… Yes No

Skin rash ……………….. Yes No

Surgery, last 5 years …… Yes No

Swelling feet or ankles …. Yes No

Stomach ulcer ………….. Yes No

Swollen glands, persistent

 in neck?……………… Yes No

Thyroid problems ……… Yes No

Tobacco Use …………… Yes No

Tuberculosis …………… Yes No

Tumor or Growth ……… Yes No

 Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vertigo …………………. Yes No

***Women***:

 Are you pregnant? …… Yes No

 Are you nursing? …… Yes No

 Taking birth control?.. Yes No

AIDS or HIV ………… Yes No

Allergies, seasonal……… Yes No
Alzheimer’s/Dementia…...Yes No

Arthritis

 or painful swollen joints. Yes No

Artificial Joints………… Yes No

 Date

Asthma or hay fever …… Yes No

Bleeding abnormally…… Yes No

Blood disorder / anemia …Yes No
Blood Pressure High/Low. Yes No

Blood Thinner/Coumadin .Yes No

Blood transfusion

 ever required? ………… Yes No

Cancer /Cancer Treatment Yes No

Chemical Dependency …. Yes No

Chest pain upon exertion Yes No

Contact lenses ………… Yes No

Cortisone treatments …. Yes No

Cough, persistent or

 that produces blood…… Yes No

Circulatory Problems……Yes No

Have you at any time tested positive and/or been diagnosed with COVID-19?.....Yes No

8. Please explain any other disease, condition, or problem not noted previously.

9. Are you taking any medicine(s) including non-prescription medicine? Yes No ***attach list if needed***

 **Please List Medications**:

10. What Pharmacy do you use for prescriptions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that this information is complete and accurate to the best of my knowledge. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature of Patient Date
- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

For completion by Dentist / Hygienist / Assistant
Comments on patient interview concerning medical history:

 \_ \*Revised 11-4-2021\*

Depression/Anxiety ……. Yes No
Diabetes/Low blood sugar Yes No

 Controlled by \_\_ Diet or \_\_ Insulin

Diarrhea persistent or

 recent weight loss …… Yes No

Epilepsy or other

 Neurological disease … Yes No

Fainting or dizziness … Yes No

Glaucoma………………. Yes No

Hearing Loss / Aid ……. Yes No

Hepatitis, Jaundice

 Or Liver Disease…… Yes No

Immune system problems Yes No

Jaw Pain ……………… Yes No

Kidney trouble ………… Yes No

Mental health problems
\_\_Bipolar, \_\_Schizophrenia, etc.…Yes No
Parkinson ’s disease…….. Yes No

Removable

 Dental appliances ……... Yes No

Respiratory problems,

 Emphysema, bronchitis, COPD …Yes No

\*If yes, approximate date of positive test\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexually transmitted

 disease, herpes ………. Yes No
Shortness of breath …… Yes No

Sinus trouble …………… Yes No
Skin rash ……………….. Yes No

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 in neck?……………… Yes No

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Tumor or Growth ……… Yes No

 Treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vertigo …………………. Yes No

Women:

 Are you pregnant? …… Yes No

 Are you nursing? …… Yes No

 Taking birth control?..