John L. Hyatt, D.D.S., M.S.

Practice Limited to Periodontics

Medical History

Name _____ Age Today _____

Medical Doctor Name _____ Phone _____

Circle

1. Have you been a patient in the hospital during the past two years? YES NO
   Please describe: _____
   _____
2. Have you ever had any operations or surgical procedures? YES NO
   Please List: _____
   _____
3. Have you been under the care of a medical doctor during the past two years? YES NO
   Please describe: _____
   _____
4. Have you ever been put to sleep, had general anesthetic, or sedation? YES NO
5. Have you or any family member had a serious reaction to or fever from an anesthetic? YES NO
6. Have you ever had any excessive bleeding requiring special treatment? YES NO
7. Do you smoke?_____ Packs per day?_____ How long? _____
8. Do you use snuff or chew tobacco? _____ How long?_____
9. Do you drink beer, wine, or liquor?_____ How often? _____
10. Please circle any of the following which you have had or have a present:

Heart Disease	Growth Disturbance	Tuberculosis	Blood Disease
Heart Attack	Diabetes	Breathing Problems	Bruise Easily
Heart Failure	Hormone Replacement	Epilepsy/Seizures	Anemia
Angina (Chest Pain)	Arthritis	Fainting/Dizzy Spells	Sickle Cell Disease
Stroke	Rheumatism	Nervous/Anxiety	Hemophilia
Heart Murmur	Artificial Joint	Glaucoma	Blood Transfusion
Artificial Heart Valve	Cortisone Injection	Headaches	Mental Illness
Poor Circulation	Steroid Therapy	Hepatitis	Psychiatric Treatment
Palpitation/Irregular Beats	Cold Sore/Fever Blister	Liver Disease	Counseling
Mitral Valve Prolapse	Asthma	Yellow Jaundice	Drug/Alcohol Abuse
Pacemaker	Bronchitis	Kidney Trouble	Depression
Heart Surgery	Pneumonia	Bleeding Problems	HIV Test
High Blood Pressure	Emphysema	Cancer	Immune Disease
Thyroid Disease	Hay Fever	Bladder Infection	AIDS
Rheumatic Fever	Cough	Stomach Problems	Sexually Transmitted Disease