Medical History

Patient Name _____

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	____ Yes	____ No	_____ N/A
Have you ever been hospitalized or had a major operation?	____ Yes	____ No	_____ N/A
Have you ever had a serious head or neck injury?	____ Yes	____ No	_____ N/A
Are you taking any medication, pills, or drugs?	____ Yes	____ No	_____ N/A
Do you take, or have you taken, Phen-Fen or Redux?	____ Yes	____ No	_____ N/A
Are you on a special diet?	____ Yes	____ No	_____ N/A
Do you use tobacco?	____ Yes	____ No	_____ N/A
Do you use controlled substances?	____ Yes	____ No	_____ N/A

Women: Are you ____ Pregnant/Trying to get pregnant? ____ Nursing? ____ Taking oral contraceptives?

Are you allergic to any of the following?

____ Aspirin ____ Penicillin ____ Codeine ____ Acrylic ____ Metal ____ Latex ____ Local Anesthetics ____ Other

Do you have, or have you had any of the following?

____ Aids/HIV	____ Alzheimer's Disease	____ Anaphylaxis
____ Anemia	____ Angina	____ Arthritis/Gout
____ Artificial Heart Valve*	____ Artificial Joint*	____ Asthma
____ Blood Disease	____ Blood Transfusion	____ Breathing Problem
____ Bruise Easily	____ Cancer	____ Chemotherapy
____ Chest Pains	____ Cold Sores/Fever Blisters	____ Convulsions
____ Congenital Heart Disorder	____ Cortisone Medicine	____ Diabetes
____ Drug Addiction	____ Easily Winded	____ Emphysema
____ Epilepsy or Seizures	____ Excessive Bleeding	____ Excessive Thirst
____ Fainting Spells/Dizziness	____ Frequent Cough	____ Genital Herpes
____ Frequent Diarrhea	____ Frequent Headaches	____ Glaucoma
____ Hay Fever	____ Heart Attack/Failure	____ Heart Murmur*
____ Heart Pace Maker*	____ Heart Trouble/Disease	____ Hemophilia
____ Hepatitis A	____ Hepatitis B or C	____ Herpes
____ High Blood Pressure	____ Hives or Rash	____ Hypoglycemia
____ Irregular Heartbeat	____ Kidney Problems	____ Leukemia
____ Liver Disease	____ Low Blood Pressure	____ Lung Disease
____ Mitral Valve Prolapse*	____ Pain in Jaw Joints	____ Psychiatric Care
____ Parathyroid Disease	____ Radiation Treatments	____ Recent Weight Loss
____ Radiation Treatments	____ Renal Dialysis	____ Rheumatic Fever*
____ Rheumatism	____ Scarlet Fever	____ Shingles
____ Sickle Cell Disease	____ Sinus Trouble	____ Spina Bifida
____ Stomach/Intestinal Disease	____ Stroke	____ Swelling of Limbs
____ Thyroid Disease	____ Tonsillitis	____ Tuberculosis
____ Tumors or Growths	____ Ulcers	____ Venereal Disease
____ Yellow Jaundice		

Have you ever had any serious illness not listed above? ____ Yes ____ No ____ N/A

Comments: _____

_____

*Condition may require medication. N/A – Not answered by patient.

Over Please

I give permission for my dentist and his/her clinical team to take any necessary x-rays, photos or study models to enable complete diagnosis and treatment.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian Date

Brogdon Dental

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