

## 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.



*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.*

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Signature of Patient, Parent, or Guardian

Date

**Brogdon Dental**

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