BROOKWOOD
DENTAL CARE

Medical History

Allergies – **circle one:**

Yes / No	Aspirin	Yes / No	Local Anesthetic
Yes / No	Codeine	Yes / No	Penicillin
Yes / No	Latex	Yes / No	Sulfa

List any other allergies: _____

Do you have/had any of the following – **circle one:**

Yes / No	High / Low Blood Pressure	Yes / No	Arthritis / Rheumatism / Gout
Yes / No	AIDS / HIV	Yes / No	Artificial Joints / Bones
Yes / No	Anemia / Bleeding Problems	Yes / No	Asthma
Yes / No	Artificial Heart Valves	Yes / No	Cancer
Yes / No	Blood Disease	Yes / No	Chemotherapy
Yes / No	Congenital Heart Lesions	Yes / No	Diabetes
Yes / No	Heart Problems	Yes / No	Emphysema
Yes / No	Pacemaker	Yes / No	Glaucoma
Yes / No	Radiation Treatment	Yes / No	Shortness of Breath
Yes / No	Sinus Trouble	Yes / No	Stroke
Yes / No	Thyroid Problems	Yes / No	Tuberculosis
Yes / No	Tumor / Growth on Head / Neck	Yes / No	Ulcer
Yes / No	Epilepsy	Yes / No	Fainting / Dizziness
Yes / No	Headaches (Frequent)	Yes / No	Hepatitis
Yes / No	Herpes	Yes / No	Kidney Disease
Yes / No	Liver Disease	Yes / No	Nervous Problems
Yes / No	Psychiatric Care		

List any other medical issues: _____

List any serious illnesses/surgeries: _____

List any medications: _____

Yes / No	Do you drink?	Yes / No	Pregnant
Yes / No	Do you smoke?	Yes / No	Nursing
Yes / No	High sugar intake?		

Signature* Date*

_____ _____