Patient Name:_____

Date of Birth ____/____/_____

CLARK F. BROWN, JR. DDS, PA
2113 SARNO ROAD, MELBOURNE, FL 32935

MEDICAL HISTORY

Office Use
ASA ☐

Have you ever had any of the following? (Circle yes or no)

Heart Attack or Disease Yes No
What type & when _____
_____
High Blood Pressure Yes No
Pacemaker Yes No
Mitral Valve Prolapse Yes No
Abnormal Bleeding Yes No
Anemia Yes No
Blood Thinners Yes No
What type? _____
Stroke Yes No
When? _____
Epilepsy or Seizures Yes No
Last seizure: _____
Joint Replacement Yes No
When? _____
Asthma or Emphysema Yes No
Use an inhaler? _____
Sinus Problems Yes No
Tobacco Use Yes No
How much? _____
Tuberculosis (TB) Yes No
Cold Sores / Fever Blisters Yes No

Please list any other medical conditions and surgeries you have or have had:
_____
_____

ALLERGIES:

Penicillin Yes No
Erythromycin Yes No
Tetracycline Yes No
Sulfa or Sulfides Yes No
Aspirin Yes No
Codeine Yes No
Latex Yes No
List other allergies: _____
_____

Cancer / Chemotherapy Yes No
Type & when? _____
_____
Radiation Therapy Yes No
Type & when? _____
HIV / AIDS Yes No
Liver Disease / Hepatitis Yes No
Type & when? _____
Diabetes Yes No
If yes, A1C:_____
Kidney Disease Yes No
Thyroid Problems Yes No
Steroid Use in past year Yes No
When & how long? _____
Bisphosphonates Yes No
(Fosamax, Boniva, Reclast, etc.)
If yes, IV_____ Oral Only _____
When taken? _____
Complications with anesthesia Yes No
Describe _____
_____

Please list all medications you are taking (including non-prescription):

Medication	**Reason**

Additional sheet attached Yes No

I certify that the information I have given on this medical history form is correct and complete to the best of my knowledge. I also understand that complete, correct and up-to-date information is important for my well-being and safety. I understand and agree that it is my responsibility to inform this office of any changes in my medical status before any treatment is rendered.

Patient Signature: _____ Date: ____/____/_____