Lee T. Brown, DDS
Nicole L. Gettings, DDS

Brown & Gettings, DDS
Creating Beautiful Smiles

8191 Beckett Park Drive
West Chester, OH 45069
(513) 860-3660

Patient name_____

MEDICAL HISTORY

Do you have any current health problems? Yes No
Please describe _____
Are you currently under the care of a physician? Yes No
Please describe_____
Physician's name and phone_____
Are you currently taking any medications or supplements? Yes No
Medication_____dose_____reason_____
Medication_____dose_____reason_____
Medication_____dose_____reason_____
Have you been in the hospital, had a serious illness, or major surgery? Yes No
_____
_____

Have you had any of the following:

Anemia
Arthritis
Artificial joints (hip,knee)
Asthma
Blood disorders
Cancer
Chemotherapy
Diabetes
Digestive disorders (gastric reflux)
Drug dependency
Emphysema
Epilepsy,seizures
Fainting,dizziness
Fever blisters (cold sores)
Glaucoma
Hay fever
Headaches
Heart attack
Heart disease
Heart murmur
Heart surgery
Hemophilia
Hepatitis (type__)
High blood pressure
Low blood pressure
HIV-AIDS
Kidney disease
Liver disease
Neurologic problems
Nervousness
Osteoporosis osteopenia
Pacemaker
Pain in jaw joints
Radiation treatment
Sinus problems
Sleeping problems
sleep apnea
told you snore
wear a CPAP
had a sleep study
Smoking/tobacco use
Stroke
Tuberculosis
Ulcers

Are you allergic to or reacted adversely to any of the following:

Any metals
Aspirin
Codeine
Erythromycin
Ibuprofen
Latex
Local anesthesia
Nitrous oxide
Penicillin

Are you aware of being allergic to any other medications or substances?_____
_____
Any other medical or dental information you feel we should know?_____
_____

The undersigned authorizes the dentist to take necessary x-rays, study models, photographs, or other diagnostic aids deemed appropriate to make a thorough diagnosis. I authorize the dentist to perform all forms of treatment that may be indicated. I understand there are certain risks with the use of anesthetic agents, and I understand I am responsible for payment of dental services for me and my dependents. I will also assign benefits to the dentist.

Patient Signature_____ Date _____