Medical/Health History

It is important that I know about your Medical History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire. ***Neeley Dental Group***

Medical History

	Yes	No
Do you have any **CURRENT HEALTH PROBLEMS**?	☐	☐
Are you under a **PHYSICIAN'S CARE** now?	☐	☐

For what? _____

_____

What **MEDICATIONS** are you currently taking?_____

_____

	Yes	No
Are you **PREGNANT**?	☐	☐

Do you use cigars/cigarette, pipe, or chewing tobacco? (please circle) Yes or No

No Yes **No Yes**

Please check of the following which you have had or presently have:

AIDS/HIV Pos.	☐☐	Hemophilia(abnormal bleeding)	☐☐	Other:	
Anaphylaxis shock	☐☐	Herpes	☐☐		
Arthritis	☐☐	Hepatitis	☐☐		
Artificial heart valves	☐☐	High Blood Pressure	☐☐		
Artificial joints	☐☐	Jaw Pain	☐☐		
Asthma	☐☐	Kidney disease or malfunction	☐☐	**Comments on Health:**	
Cancer	☐☐	Liver disease	☐☐		
Chemical dependency	☐☐	Mitral valve prolapse	☐☐		
Chemotheropy	☐☐	Pacemaker/heart surgery	☐☐		
Circulatory problems	☐☐	Radiation treatment	☐☐		
Cortisone treatments	☐☐	Respiratory disease	☐☐		
Diabetes	☐☐	Shortness of Breath	☐☐		
Epilepsy	☐☐	Stroke	☐☐		
Fainting	☐☐	Tuberculosis	☐☐		
Heart murmur	☐☐	Headaches	☐☐		
Heart problems	☐☐	Nervous Disorders	☐☐		

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Asprin_____ Local Anesthetic_____ Erthromycin_____ Latex_____ Nitrous Oxide_____ Codeine_____ Penicillin_____

Are you aware of being allergic to any other medications or substances? If yes please list_____

_____

Family Physician_____ **PHONE**_____

PATIENT SIGNATURE_____ **DATE**_____