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

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

For what? _____

_____

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

_____

	No	Yes
Are you **PREGNANT**?	☐	☐

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

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

	No	Yes		No	Yes
AIDS/HIV Pos.	☐	☐	Hemophilia(abnormal bleeding)	☐	☐
Anaphylaxis shock	☐	☐	Herpes	☐	☐
Arthritis	☐	☐	Hepatitis	☐	☐
Artificial heart valves	☐	☐	High Blood Pressure	☐	☐
Artificial joints	☐	☐	Jaw Pain	☐	☐
Asthma	☐	☐	Kidney disease or malfunction	☐	☐
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	☐	☐

Other:

_____

_____

Comments on Health:

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**_____