NEAL FAMILY DENTAL

Medical History

Date:_____

Last Name_____**First**_____**MI**___ **Birthdate:**_____

1) Your Impression of Your Overall Health: Excellent Good Fair Poor **2) Year of last physical:**_____

3) Physician's Name:_____**Address:**_____**Phone:**_____

4) Check any medications or material you are allergic/sensitive to: □ Aspirin □Antibiotics (Penicillin, Erythromycin, Sulfa) □ Codeine/Other Narcotics □ Latex □ Metals □ Shellfish □Epinephrine □Anesthetics: _____ □Other:_____

5) Do you use any of the following?

- Anticoagulants (Blood Thinners) **□Y □N**
- Aspirin or drugs like such as Motrin, Aleve, Ibuprofen **□Y □N**
- Bisphosphonates (Actonel, Aredia, Boniva, Fosamax, Zometa) **□Y □N**
- High Blood Pressure **□Y □N**
- Digitalis, Inderal, Nitroglycerin, or other heart Meds **□Y □N**
- Steroids (Cortisone, etc.) **□Y □N**
- Tranquilizers **□Y □N**

6) Please circle any medical conditions you may have:

Alcohol/Drug Abuse	Congenital Heart Defect	High Cholesterol	Rheumatic or Scarlet Fever
Anemia/Leukemia	Diabetes	HIV+/AIDS	Shingles
Anorexia/Bulimia	Emphysema	Hives/Rash	Sickle Cell Trait
Arthritis: Rheumatoid/Osteo	Epilepsy/Seizures	Hospitalization	Sinus Issues
Artificial Joints/Valves	Fainting/Dizzy Spells	Kidney Problems	Stroke
Asthma/Hay fever	Headaches/Migraines	Liver Disease	Swollen Ankles
Bleeding Problems	Heart Attack	Low Blood Pressure	TB, Emphysema, or other
Blood Transfusion	Heart Murmur	Mental Health Issues	lung disease
Bronchitis	Heart Surgery	Mitral Valve Prolapse	Total Joint Replacement
Cardiac pacemaker	Hemophilia	Osteoporosis/Osteopenia	Tumors/Cancer: _____
Chemotherapy/Radiation	Hepatitis (A, B, C)	Pace Maker	Ulcers
Treatment	Herpes/Fever Blisters	Pneumonia	
Chest Pain/	High Blood Pressure	Prosthetic Heart Valve	

Other Medical Conditions/Diseases: _____

7) Please list any and all medications taken in the last month, including prescription medication, over-the-counter medications, supplements herbal or holistic remedies, vitamins or minerals:

_____ _____ _____

_____ _____ _____

8) Do you use tobacco products ? □Y □N (If Yes, please circle type and give frequency) **FREQUENCY:**_____

SMOKE: CIGARETTES CIGAR PIPE **SMOKELESS:** CHEWING TOBACCO, SNUFF, DIP, ELECTRONIC CIGARETTE

9) Women: Are you taking birth control pills? **□Y □N** Are you pregnant? **□Y □N** Nursing? **□Y □N**

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

PATIENT SIGNATURE X_____**DATE:**_____

Changes in Medical History? **Notes:**

□Y □N PATIENT SIGNATURE:_____**DATE:**_____**BP:** _____ _____

□Y □N PATIENT SIGNATURE:_____**DATE:**_____**BP:**_____ _____

□Y □N PATIENT SIGNATURE:_____**DATE:**_____**BP:**_____ _____

DENTIST SIGNATURE X_____**DATE:**_____

Reviewer/date_____ **Reviewer/date**_____ **Reviewer/date**_____ **Reviewer/date**_____ **Reviewer/date**_____