Jennifer A. Neise, DDS, PC

Medical History

_____ _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with dentistry you will receive.

Changes in your general health in the past year? Yes No

If yes, please explain: _____

Date of last physical exam: _____ Name of Physician: _____

Are you under a physician's care now? Yes No

If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No

If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No

If yes, please list: _____

Have you ever been hospitalized or had a major operation? Yes No

If yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No

Do you take, or have you taken, Phen-Fen or Redux? Yes No Are you on a special diet? Yes No

Do you use tobacco? Yes No Do you use controlled substances? Yes No

Women are you:

Pregnant/trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal

☐ Latex ☐ Sulfa drugs ☐ Other Please explain:

_____

Do you have or have you had any of the following:

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No

Asthma	Yes No	Fainting/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problem	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Tonsillitis	Yes No	Mitral Valve Prolapse	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No	Cold Sores/Fever Blisters	Yes No
Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No	Convulsions	Yes No
Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No	Yellow Jaundice	Yes No
Blood Thinners	Yes No	Acid Reflux	Yes No	Congenital Heart Disorder	Yes No		

Have you ever had any serious illness not listed above? Yes No

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Comments:

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I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I am aware it is my responsibility to inform the dental office of any changes in medical status.

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OFFICE USE ONLY Reviewed By: DATE:

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