Patient Medical Record

Patient Name _____ Date _____

Name and address of physician (Medical Doctor): Name _____ City _____

Have you been under a physician's care during the past 2 years? _____ For _____

Have you ever had major surgery? _____ If yes, date and procedure _____

_____

Do you smoke or use tobacco in any form? _____ If so, what type and how much? _____

Are you allergic to latex? ❑ yes ❑ no

Please list all of your current medications and patches: _____

_____

Please check any of the following that you are allergic to or have had a bad reaction to:

❑ Local Anesthetics ❑ Codeine ❑ Sulfa Drugs ❑ Iodine ❑ Erythromycin
❑ Aspirin ❑ Penicillin ❑ Barbiturates ❑ Latex ❑ Other _____

Women: Are you pregnant or think you may be pregnant? ❑ yes ❑ no Nursing? ❑ yes ❑ no Taking birth control pills? ❑ yes ❑ no

Place a mark on "yes" or "no" to indicate if you have had any of the following:

	yes	no		yes	no
Acid Reflux	❑	❑	Drug Dependency	❑	❑
ADHD	❑	❑	Dry Mouth/Dry Socket	❑	❑
Aids/HIV	❑	❑	Emphysema	❑	❑
Alcoholism	❑	❑	Epilepsy	❑	❑
Allergies or Hives	❑	❑	Fainting or Dizzy Spells	❑	❑
Anemia	❑	❑	Glaucoma	❑	❑
Anxiety Disorder/Panic Attacks	❑	❑	Hay Fever/Sinus Trouble	❑	❑
Angina Pectoris (Chest pain)	❑	❑	Head Trauma	❑	❑
Artificial Heart Valve	❑	❑	Hearing Impaired	❑	❑
Artificial Joints (Hip, Knee)	❑	❑	Heart Condition	❑	❑
Asthma	❑	❑	Heart Pacemaker	❑	❑
Bipolar Disorder	❑	❑	Hemophilia or Prolonged Bleeding	❑	❑
Blood Transfusion	❑	❑	Hepatitis A, B, C	❑	❑
Bruise Easily	❑	❑	Herpes	❑	❑
Cancer	❑	❑	Hypoglycemia	❑	❑
Cataract or Lens Replacement	❑	❑	Immune Deficiency Disease	❑	❑
Cerebral Palsy	❑	❑	Irritable Bowel Syndrome	❑	❑
Chemotherapy/Radiation	❑	❑	Kidney Trouble	❑	❑
Chicken Pox	❑	❑	Liver Disease	❑	❑
Chronic Cough	❑	❑	Low/High Blood Pressure	❑	❑
Chronic Fatigue Syndrome/Fibromyalgia	❑	❑	Mitral Valve Prolapse	❑	❑
Claustrophobia	❑	❑	Mono	❑	❑
Cold Sores/Fever Blisters	❑	❑	Nervousness	❑	❑
Congenital Heart Lesions	❑	❑	Psychiatric Treatment	❑	❑
Convulsions or Seizures	❑	❑	Stroke	❑	❑
Cosmetic Surgery	❑	❑	TMJ Syndrome/Pain in Joint	❑	❑
Depression	❑	❑	Tuberculosis (TB)	❑	❑
Diabetes	❑	❑	Ulcers	❑	❑
Downs Syndrome	❑	❑	Vertigo	❑	❑

Have you had any disease, condition, or medical situation not previously listed? _____

Medical Release: I understand that the information contained in my case record is confidential. However, I give my consent for David P. Ney, D.D.S., PA to release to my physician any information which may be helpful in his/her understanding of my present health situation.

Patient Signature _____ Date _____