Dr. Neumann, Dr. Dabbert and Dr. Hough

Serenity Dental
12221 Giles Road
LaVista, NE 68128
(402) 339-6078
healthysmilesNE@gmail.com

WEEPING WATER DENTAL
105 W. Eldora Avenue
Weeping Water, NE 68463
(402)267-2325
infor@weepingwaterdental.com

Medical History

Please answer the following questions as accurately as possible. Many health conditions and medications have an impact on your oral health, or may affect your dental treatment. Thank You!

Do you see a physician for routine check-ups? ☐ Yes ☐ No
Are you currently seeing a physician for a specific health condition? ☐ Yes ☐ No
If you answered Yes to either of the above, please provide your physicians name/clinic

Within the last 2 years, have you been hospitalized or had a major operation? ☐ Yes ☐ No
In yes, please explain
Have you ever had a serious head or neck injury? ☐ Yes ☐ No
If yes, please explain
Are you currently taking any medications, pills, or supplements? ☐ Yes ☐ No
If yes, please list:

Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Acrylic ☐ Metal
Latex ☐ Local Anesthetics ☐ Other Known Allergies

Women:
Are you pregnant/trying to conceive? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No
Nursing? ☐ Yes ☐ No

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Please Indicate which of the following conditions apply to you or have in the past:

AIDS/HIV Positive ☐ Y ☐ N
Alzheimers Disease/Dementia ☐ Y ☐ N
Anaphylaxis ☐ Y ☐ N
If yes, please explain

Artificial Heart Valve ☐ Y ☐ N
Artificial Joint ☐ Y ☐ N
If yes, please indicate the location of the joint and year placed

Asthma ☐ Y ☐ N
Blood Disease/Hemophilia/Anemia ☐ Y ☐ N
If yes, please explain

Blood Transfusion ☐ Y ☐ N
Cancer/Leukemia ☐ Y ☐ N
If yes, please explain

Did you undergo Chemotherapy? ☐ Y ☐ N
Did you under Radiation Therapy? ☐ Y ☐ N
Cold Sores/Fever Blisters ☐ Y ☐ N
Cortisone Medication ☐ Y ☐ N
Diabetes ☐ Y ☐ N
If yes, is it controlled with medication? ☐ Y ☐ N
Drug Abuse/Addiction ☐ Y ☐ N
Lung Disease/Emphysema/COPD ☐ Y ☐ N
If yes, please explain

Fainting Spells/Dizziness ☐ Y ☐ N
Migraines/Frequent Headaches ☐ Y ☐ N
Glaucoma ☐ Y ☐ N

Heart Attack/Disease/Condition ☐ Y ☐ N
If yes, please explain

Do you have a pacemaker? ☐ Y ☐ N
Hepatitis ☐ Y ☐ N
If yes, which type

Herpes ☐ Y ☐ N
High Blood Pressure ☐ Y ☐ N
If yes, is it controlled with medication? ☐ Y ☐ N
High Cholesterol ☐ Y ☐ N
If yes, is it controlled with medication? ☐ Y ☐ N
Hives/Rash ☐ Y ☐ N
Hypoglycemia ☐ Y ☐ N
Kidney Issues ☐ Y ☐ N
If yes, are you on Dialysis? ☐ Y ☐ N
Low Blood Pressure ☐ Y ☐ N
Osteoporosis ☐ Y ☐ N
If yes, do you take medication? ☐ Y ☐ N
Shingles ☐ Y ☐ N
Chronic Sinusitis ☐ Y ☐ N
Stomach/Intestinal Issues ☐ Y ☐ N
If yes, explain

Stroke ☐ Y ☐ N
If yes, do you take medication that can cause excess bleeding? ☐ Y ☐ N
Thyroid Disease ☐ Y ☐ N
Tuberculosis ☐ Y ☐ N
Tobacco Use ☐ Y ☐ N
Do you still use tobacco? ☐ Y ☐ N
Any conditions not listed above ☐ Y ☐ N
If yes, explain

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients health) It is my responsibility to inform the dental office of any changes in medical status
SIGNATURE OF PATIENT/PARENT/GUARDIAN

DATE