Time 12:55 PM | James River Dentistry | Date 11/24/2015

MEDICAL HISTORY FORM

Patient Name: | Birth Date: | Date Created:

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Have you ever had a joint replacement or artificial heart valve? When?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant? ☐ Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	○ Yes ○ No	If yes
Other?	☐	If yes

Do you have, or have you had, any of the following?

Heart Trouble/Disease	○ Yes ○ No	AIDS/HIV Positive	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Heart Pacemaker	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Glaucoma	○ Yes ○ No
Heart Murmur	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Drug Addiction	○ Yes ○ No
Heart Attack/Failure	○ Yes ○ No	Liver Disease	○ Yes ○ No	Arthritis/Gout	○ Yes ○ No
High Blood Pressure	○ Yes ○ No	Shingles	○ Yes ○ No	Rheumatism	○ Yes ○ No
Low Blood Pressure	○ Yes ○ No	Leukemia	○ Yes ○ No	Breathing Problems/Asthma	○ Yes ○ No
Mitral Valve Prolapse	○ Yes ○ No	Cancer	○ Yes ○ No	Emphysema	○ Yes ○ No
Angina/Chest Pains	○ Yes ○ No	Chemotherapy	○ Yes ○ No	Ulcers	○ Yes ○ No
Rheumatic Fever	○ Yes ○ No	Radiation Treatments	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Hemophilia	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Anaphylaxis	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Cold Sores/Fever Blisters	○ Yes ○ No
Anemia	○ Yes ○ No	Alzheimer's Disease	○ Yes ○ No	Hay Fever	○ Yes ○ No
Excessive Bleeding	○ Yes ○ No	Stroke	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
High Cholesterol	○ Yes ○ No	Epilepsy/Seizures	○ Yes ○ No	Cortisone Medication	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Convulsions	○ Yes ○ No	Diabetes	○ Yes ○ No
Frequent Headaches	○ Yes ○ No				

Have you ever had any serious illness not listed	○ Yes ○ No	If yes

Comments:

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____