JAMES RIVER DENTAL

Health History

All information is confidential

Patient's Name: _____ Date of Birth: _____

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 the dentistry you will receive.

Are you under a Physician's care now? If yes, list physician's name and phone #	Y	N	
Have you ever been hospitalized or had a major operation?	Y	N	Explanation:
Have you ever had a serious head or neck injury?	Y	N	
Are you taking any medications including non-prescription drugs, vitamins and herbs?	Y	N	List:
Are you required to take an antibiotic (pre-medication) before having dental treatment?	Y	N	Reason:
Do you take, or have you taken Phen-Fen or Redux?	Y	N	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Y	N	
Do you use tobacco/nicotine products?	Y	N	Type:

Any drug or food allergies? **YES NO** If so, please list them here:_____

_____

Are you allergic to latex? (Please circle) **YES NO**

Women:	**Y**	**N**		**Y**	**N**
Are you pregnant?			Are you nursing?		
-Estimated Due Date:			Are you taking any birth control prescriptions?		

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JAMES RIVER
DENTAL

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

ADD/ADHD	**Y**	**N**	**Aids/HIV**	**Y**	**N**	**Alcoholism**	**Y**	**N**	**Allergies/Hives**	**Y**	**N**
Anemia	**Y**	**N**	**Arthritis/Gout**	**Y**	**N**	**Artificial Heart Valve**	**Y**	**N**	**Asperger Syndrome/Autism**	**Y**	**N**
Aspirin Therapy/ Blood Thinner	**Y**	**N**	**Asthma/Breathing problems**	**Y**	**N**	**Blood Transfusion**	**Y**	**N**	**Chest Pains**	**Y**	**N**
Cold Sores/ Fever Blisters	**Y**	**N**	**Dementia/ Alzheimer's**	**Y**	**N**	**Diabetes**	**Y**	**N**	**Dizziness/Fainting**	**Y**	**N**
Epilepsy/ Seizures	**Y**	**N**	**Excessive Bleeding**	**Y**	**N**	**Frequent Headaches**	**Y**	**N**	**Gastrointestinal Issues**	**Y**	**N**
Hearing Difficulty/ Impaired	**Y**	**N**	**Heart Disease**	**Y**	**N**	**Heart Murmur**	**Y**	**N**	**Heart Attack/Failure**	**Y**	**N**
Hepatitis A	**Y**	**N**	**Hepatitis B or C**	**Y**	**N**	**High Blood Pressure**	**Y**	**N**	**Low Blood Pressure**	**Y**	**N**
Joint Replacement	**Y**	**N**	**Kidney Disease/ Dialysis**	**Y**	**N**	**Liver Disease**	**Y**	**N**	**Lung Disease**	**Y**	**N**
Mitral Valve Prolapse	**Y**	**N**	**Mouth Sores/ Growths**	**Y**	**N**	**Osteoporosis (Bone Disease)**	**Y**	**N**	**Pace Maker/Heart Surgery**	**Y**	**N**
Pain in Jaw	**Y**	**N**	**Psychiatric Treatment**	**Y**	**N**	**Recreational Drug Use**	**Y**	**N**	**Rheumatic Fever**	**Y**	**N**
Ringing in ears	**Y**	**N**	**Sinus Problems**	**Y**	**N**	**Stroke**	**Y**	**N**	**Thyroid Disease**	**Y**	**N**
Tuberculosis (TB)	**Y**	**N**	**Venereal Disease**	**Y**				**N**			

Do you have, or have you had any type of Cancer **YES NO** If yes, what type?_____

If you have had Cancer, did you receive any of the following treatments?

Chemotherapy **YES NO** Radiation Treatment **YES NO**

Have you ever had any serious illness or disease not listed above? **YES NO**

If yes_____

I have read and completed all items in good faith and as accurately as possible.

Patient/Guardian Signature _____ **Date** _____