JAMES RIVER DENTAL

Medical History

All information is confidential

Patient's Name: _____ Date of Birth: _____

List all medications you are currently taking including non-prescription drugs, vitamins and herbs: (If you have a list with you, we will be glad to copy it and include it in your file.) _____

_____

_____

Are you allergic to any medications? If so, please list them here: _____

_____

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

Physician's Name and Phone #: _____

Are you required to take an antibiotic (pre-medication) before having dental treatment? (Circle) **YES NO**

Do you have now or have a history of any of the following (please mark each item either yes or no, DO NOT LEAVE ANY BLANK):

	Y	N		Y	N		Y	N
ADD/ ADHD			Excessive Bleeding			Psychiatric Treatment		
Aids/ HIV			Frequent Headaches			Recreational Drug Use		
Alcoholism			Gastrointestinal Issues			Rheumatic Fever		
Allergies/ Hives			Hearing difficulty/ impaired			Ringing in Ears		
Anemia			Heart Disease			Sinus Problems		
Arthritis			Heart Murmur			Stroke		
Asperger Syndrome/ Autism			Hepatitis (Circle: A B C)			Thyroid Disease		
Aspirin Therapy/ Blood Thinner			High Blood Pressure			Tuberculosis (TB)		
Asthma/ Breathing Problems			Low Blood Pressure			Use of Tobacco Products		
Blood Transfusion			Joint Replacement			Venereal Disease		
Cancer (Type:)			Kidney Disease			Other Disease/ Illness/Condition:		
-Chemotherapy			-Dialysis					
-Radiation Treatment			Latex Allergy					
Chest Pain			Liver Disease					
Dementia			Lung Disease					
Diabetes			Mitral Valve Prolapse					
Dizziness/ Fainting			Mouth Sores/ Growths					
Epilepsy/ Seizures			Pace Maker/ Heart Surgery					

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

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

Patient/Guardian Signature _____ **Date** _____