Advanced Dentistry of Richmond
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Medical History

Date:_____ **Patient's Name:**_____ **DOB:**_____

Do You Currently Have Or Have You Ever Had:

_____ Abnormal Bleeding-Hemophilia
_____AIDS/HIV
_____Alcohol/Drug Abuse
_____Alzheimer's Disease
_____Anaphylaxis
_____Anemia
_____Arthritis
_____Asthma-exercise/allergy induced
_____Autoimmune Disease
_____Back Problems
_____Blood Transfusions
_____Bone/Joint Replacement
_____Breathing Difficulty-COPD/ Emphysema
_____Cancer/Tumors
_____Chemotherapy
_____Cold Sores-Herpes
_____Colitis
_____Diabetes
_____Dry Mouth
_____Epilepsy/Seizures
_____Fainting
_____Glaucoma
_____Hay Fever
_____Heart issues:
Arrythmia
Attack
Congenital Heart Defect
Congestive Heart Failure
Pacemaker/Stent
_____Hepatitis A/ B/ C
_____High Blood Pressure
_____High Cholesterol
_____Hypoglycemia
_____Kidney Disease/Dialysis
_____Leukemia
_____Liver Disease
_____Meniere's Disease/Vertigo(dizzy)
_____Nervous Disorder
_____Osteoporosis/Osteopenia
_____Parkinson's Disease
_____Pain in Jaw Joints-TMD
_____Psychiatric Care
_____Radiation Treatments
_____Shingles
_____Sickle Cell Disease
_____Sinus Problems
_____Sleep Apnea/C-Pap machine
_____Spina Bifida
_____Stomach/Digestive Problems
_____Stroke
_____Swelling of Limbs
_____Thyroid-Hypo/Hyperthyroidism
_____Tuberculosis Disease or Latent TB
_____Ulcers
_____Venereal Disease/HPV

Are You Allergic To Or Have Had Reactions To:

A. Local Anesthetic(Dental Anesthesia)? Y N
B. Penicillin, Tetracycline, Erythromycin, Or other antibiotics?:_____ Y N
C. Sulfa Drugs? Y N
D. Aspirin? Y N
E. Acrylic? Y N
F. Codeine? Y N
G. Latex? Y N
H. Metal? Y N
I. Milk? Y N
J. Nuts? Y N
K. Other? _____

Medical History:

1. Physician's Name_____ Office #_____
2. Are you under the care of a physician now? (Explain, if yes)_____
3. Have you needed emergency care within the past few years?(Explain, if yes)_____
4. Name of previous dental office/Dentist's name?_____
5. Do you smoke or use tobacco in any form? Y N
6. List all medication currently taking; include prescription, over the counter and supplements._____
_____
_____
7. Have you taken/or currently taking Fosamax, Prolia, Boniva, Actonel or any other Bisphosphonates? Y N
8. Do you require antibiotic premedication prior to dental treatment? Y N
9. Pharmacy/location/phone #_____
10. Women: Are you pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

To the best of my knowledge, and for my own safety, the questions on this form have been accurately answered.

Patient, Parent Or Guardian Signature_____ **Date**_____