Fairfax Advanced Dentistry

3930 Pender Drive, Suite 150 • Fairfax, VA 22030 (703)650-9299

Please fill out your current medical history as our records indicate that we have not seen you for quite some time.

Patient Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Physician

_____

_____

Office Phone _____

Date of last exam _____

1. Are you under medical treatment now? ◯ Yes ◯ No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ◯ Yes ◯ No

If yes, please explain ◯ Yes ◯ No

3. Are you taking any medication(s) including non-prescription medicine? ◯ Yes ◯ No

If yes, what medication(s) are you taking?

_____

_____

4.Have you ever taken Phen-fen/Redux? ◯ Yes ◯ No

5. Do you use tabacco? ◯ Yes ◯ No

6. Do you use controlled substances? ◯ Yes ◯ No

7.Are you wearing contact lenses? ◯ Yes ◯ No

9. Are you allergic to or have you had any reactions to the following:

Local Anesthetics (eg. novacain) ◯ Yes ◯ No

Penicillin or other antibiotics ◯ Yes ◯ No

Sulfa drags ◯ Yes ◯ No

Barbiturates ◯ Yes ◯ No

Sedatives ◯ Yes ◯ No

Iodine ◯ Yes ◯ No

Aspirin ◯ Yes ◯ No

Any metals (eg. nickel, mercury, etc...) ◯ Yes ◯ No

Latex rubber ◯ Yes ◯ No

Other _____

10. Women only:

Are you pregnant ot think you may be pregnant? ◯ Yes ◯ No

Are you nursing? ◯ Yes ◯ No

Are you taking oral contraceptives? ◯ Yes ◯ No

11. Do you have or have you had any of the following?

◯ Yes ◯ No

- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Other
- ☐ Allergies
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Erythro
- ☐ Allergy - Hay Fever
- ☐ Allergy - Latex
- ☐ Allergy - Other
- ☐ Allergy - Penicillin
- ☐ Allergy - Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Other
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

Other

_____

_____

Signature _____ **Date** _____

Response Date: ____/____/_____