Blue RidgeFamily Dentistry

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434-296-5250

PATIENT HEALTH RECORD AND PHYSICAL EVALUATION

Please be accurate. It will help us provide you a safe and comprehensive dental treatment

Patient Name:_____ Today's Date_____
Physician's Name:_____ Physician Phone:_____

Please answer the following questions. If you answer yes, please explain in the space provided.:

Yes	No	
❒	❒	Have you ever been a patient in the hospital during the past two years? ……
❒	❒	Have you been under the care of a medical doctor during the past two years? ……
❒	❒	Have you taken any medication or drugs during the past two years? ……
❒	❒	Have you ever had any excessive bleeding requiring special treatment? …….
❒	❒	Has your medical doctor ever said you have cancer or a tumor? …….
❒	❒	Have you lost more than 10 pounds in the last year?.....
❒	❒	Have you ever taken Fen-Phen?.....
❒	❒	Do you ever wake up from sleep due to shortness of breath? ……..
❒	❒	When you walk up stairs, or take a walk, do you ever stop due to pain in your chest, shortness of breath, or because you are tired?.....
❒	❒	Are you allergic to (i.e. itching, rash, swelling of hands, feet, or eyes) or made sick by Penicillin, Aspirin, Codeine, Vicodin, Latex, or any other drug or medicine?.....
❒	❒	Do you have any other non-medicinal allergies such as metals? ……..
❒	❒	Do you have a history of bisphosphonate use? ……
❒	❒	Do you have a history of Coumadin or Heparin use? ……
❒	❒	Are you currently or have you ever received dialysis treatment?.....…….
❒	❒	Do you have Osteoporosis? ……

Please check if you have or ever had any of the following conditions:

Yes	No		Yes	No		Yes	No	
❒	❒	Heart Failure	❒	❒	Heart Disease or Attack	❒	❒	AIDS
❒	❒	Heart Pacemaker	❒	❒	Anemia	❒	❒	HIV+
❒	❒	Heart Murmur	❒	❒	Ulcers	❒	❒	Yellow Jaundice
❒	❒	Heart Surgery	❒	❒	Glaucoma	❒	❒	Hepatitis A (infection)
❒	❒	Angina Pectoris	❒	❒	Pain in Jaw Joint	❒	❒	Hepatitis B (serum)
❒	❒	High/Low Blood Pressure	❒	❒	Tuberculosis (TB)	❒	❒	Drug or Alcohol Abuse
❒	❒	Stroke	❒	❒	Sinus Trouble			
❒	❒	Hemophilia	❒	❒	Hay Fever/Allergies	❒	❒	Venereal Disease
❒	❒	Artificial Heart Valve	❒	❒	Allergy to Latex	❒	❒	Cold Sores
❒	❒	Artificial Joints	❒	❒	Diabetes	❒	❒	Epilepsy or Seizures
❒	❒	Asthma	❒	❒	Thyroid Disease	❒	❒	Fainting or Dizzy Spell
❒	❒	Respiratory Disease	❒	❒	X-Ray or Cobalt Treatment	❒	❒	Nervousness
❒	❒	Emphysema	❒	❒	Chemotherapy (Cancer. Leukemia)	❒	❒	Psychiatric Treatment
❒	❒	Chronic Bronchitis	❒	❒	Arthritis	❒	❒	Sickle Cell Disease
❒	❒	Kidney Trouble	❒	❒	Rheumatism	❒	❒	Bruise Easily

Do you have any disease, condition or problem not listed?.....
Women Only: Are you pregnant? ……Nursing? ……..Due Date:…….Are you using Birth Control Pills?.....…

Please list any medications (prescription and over the counter) you are taking:

_____

_____

To the best of my knowledge, all of the proceeding answers are true and correct. If I ever have any changes in my health, or my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Patient Signature…… Date:……..…….

Submit

Physical Evaluation Results: BP: _____
Pulse: _____

Doctor Signature: _____ Treatment Signature Coordinator _____