Steadman Family Dentistry
Stony Point Medical Park
9220 Forest Hill Ave., Ste. A5
Richmond, VA 23235

Steadman Family Dentistry

Drs. Robert & Grant Steadman
Phone: 804-272-3200
Fax: 804-330-5516
www.steadmandental.com

MEDICAL HISTORY & GENERAL HEALTH INFORMATION

Before starting treatment, we need some basic health information to ensure we provide the best oral care possible. All information is confidential.

GENERAL INFORMATION

Patient Name:_____ Date of Birth*(MM/DD/YY)*:_____

Who is your Primary Care Physician(PCP)?_____ Last Exam Date:_____

Please list any medication(s) you are currently taking:_____

_____

Are you allergic to: Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Household Bleach

Please list any other allergies:_____

Have you ever taken: Phen-Fen Redux Fosamax Boniva Actonel Other Bisphosphonate:_____

Have you ever been hospitalized, had a major operation, or had a major injury to your head or neck? *Yes* *No*

_____

Are you taking any herbal suppplements or on a special diet? *Yes* *No* _____

Do you currently use or have you ever used tobacco products? *Yes* *No* _____

Do you use any controlled substances? *Yes* *No* _____

WOMEN

Are you currently pregnant or trying to get pregnant? *Yes* *No* Are you currently nursing? *Yes* *No*

Are you currently taking oral contraceptives? *Yes* *No* _____

MEDICAL CHECKLIST *(Please check all that apply)*

All information is kept strictly confidential.

AIDS/HIV Positive	Convulsions	Hepatitis A	Radiation Treatments
Alzheimer's Disease	Cortisone Medicine	Hepatitis B or C	Recent Weight Loss
Anaphylaxis	Diabetes	Herpes	Renal Dialysis
Anemia	Drug Addiction	High Blood Pressure	Rheumatic Fever
Angina	Emphysema	High Cholesterol	Scarlet Fever
Arthritis/Gout	Epilepsy or Seizures	Hives or Rash	Shingles
Artificial Heart Valve	Excessive Bleeding	Hypoglycemia	Sickle Cell Disease
Artificial Joint	Fainting Spells/Dizziness	Irregular Heartbeat	Sinus Trouble
Asthma	Frequent Cough	Kidney Problems	Spina Bifida
Blood Disease	Frequent Diarrhea	Leukemia	Stomach/Intestinal Disease
Blood Transfusion	Frequent Headaches	Liver Disease	Stroke
Breathing Problems	Glaucoma	Low Blood Pressure	Swelling of Limbs
Bruise Easily	Hay Fever	Lung Disease	Thyroid Disease
Cancer	Heart Attack/Failure	Mitral Valve Prolapse	Tonsillitis
Chemotherapy	Heart Murmur	Osteoporosis	Tuberculosis
Chest Pains	Heart Pacemaker	Pain in Jaw Joints	Ulcers
Cold Sores/Fever Blisters	Heart Trouble/Disease	Parathyroid Disease	Yellow Jaundice
Congenital Heart Disorder	Hemophilia	Psychiatric Care	Other: *(please detail below)*

Have you had a serious illness not listed above? *Yes* *No* *If yes, please detail below*_____

_____

_____

CONSENT

I certify that the questions on this form have been answered accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my(or the patient's) health, and that it is my responsibility to notify the dental office of any changes in medical status. I also understand that this consent will remain in effect until treatment is terminated either by myself or the dentist.

*Printed Name of Patient (or Patient Representative):*_____

*Signature of Patient (or Patient Representative):*_____ *Date:*_____

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