Blue Ridge Family Dental
Rachael Schuette D.D.S.

It is important to be as complete as possible when filling out your medical history. Health problems including past or current medications can have an impact in your oral health or in the way we treat you.

Patient Name:

Last	First	MI	Preferred Name

Are you currently under the care of a physician. If yes please describe below:

If you have ever been hospitalized or had a major operation please explain:

Have you ever taken bone density medications such as Fosamax, Boniva, Actonel or any additional medications containing bisphosphonates? If yes, please explain:

Please list your current medications:

Are you taking any controlled substances? If so please explain:

FEMALE PATIENTS:

Are you currently pregnant or nursing? ☐ No/NA

☐ Yes -Pregnant ☐ Yes- Nursing

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Please check all that apply to you below.

- [ ] *Pre-Med Dental Tx
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy -Acrylic
- [ ] Allergy -Local Anes
- [ ] Allergy -Metals
- [ ] Allergy-Seasonal
- [ ] Alzheimer's/Dementia
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Angina/Chest Pains
- [ ] Arthritis/Gout
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Breathing Problems
- [ ] Breathing Problems
- [ ] Bruise Easliy
- [ ] Cancer
- [ ] Chemo History
- [ ] Cold Sores
- [ ] Cong Heart Defect
- [ ] Cortisone Medication
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Epilepsy/Sezuires
- [ ] Excessive Bleeding
- [ ] Excessive Thirst
- [ ] Fainting/Dizziness
- [ ] Frequent Cough
- [ ] Frequent Headaches
- [ ] Heart Attack
- [ ] Heart/Valve Problems
- [ ] Hepatitis/Liver Dis
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] HIV/AIDS
- [ ] Jaundice
- [ ] Kidney Problems
- [ ] Nervous Disorders
- [ ] Osteoprosis
- [ ] Other
- [ ] Pacemaker
- [ ] Pain in Jaw Joints
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Rapid Weight Loss
- [ ] Sickle Cell Disease
- [ ] Sinus Problems
- [ ] Stomach Dis/Reflux
- [ ] Stroke
- [ ] Swelling in Limbs
- [ ] Thyroid Disease
- [ ] Tobacco User
- [ ] Tuberculosis
- [ ] Tumors

Have you ever had any serious illness not listed above?

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Blue Ridge Family Dental of any changes in my medical status.

_____ _____

Signature Date