Richard J Gray DDS
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Midlothian VA 23113
804-378-9152

Medical History

Do you have or have you had any of the following?
Please circle Y for yes or N for no

Y N Current Med. Treatment
Y N Previous Endocarditis
Y N High Blood Pressure
Y N Respiratory/Asthma
Last asthma attack:_____
Y N Rheumatic Fever
Y N Heart Attack
Y N Immunocompromised
Y N Anemia/Bleeding
Y N Diabetes/Kidney
Y N Herpes
Y N Thyroid/Hormonal

Y N Hypoglycemia
Y N Tobacco Use
Y N Shortness of Breath
Y N Cancer
Type:_____
Y N Tuberculosis
Y N Fatigue
Y N Swelling
Y N HIV/AIDS
Y N Hepatitis
Y N Ulcers/Digestive
Y N Migraine/Headaches

Y N Epilepsy/Fainting
Last episode:_____
Y N Glaucoma/Visual
Y N Mental/Neural
Y N Tumor/Neoplasms
Y N Alcoholism/Addiction
Y N Infectious Diseases
Y N Venereal Diseases
Y N Psychiatric Care
For:_____
Y N TMJ
Y N Heart Disease

Y N Heart Murmur/Defect
Y N Pacemaker
When placed:_____
Y N Irregular Heart Beat
Y N Prosthetic Implant
Y N Any Transplant
Type:_____
Y N Joint Replacement
Y N Arthritis
OTHER:_____
_____
_____

For Women: Are you pregnant? No Yes How far along? _____ Are you currently taking birth control? No Yes
Are you nursing? No Yes

If you have had any surgery, please list what it was, the date, and if there were any complications below:
Surgery_____ Date_____ Complications_____
Surgery_____ Date_____ Complications_____
Surgery_____ Date_____ Complications_____
If you have been hospitalized, please list the reason why, the date, and if there was any treatment or complications below:
Reason_____ Date_____ Treatment/Complications_____
Reason_____ Date_____ Treatment/Complications_____

Allergies

Please circle Y for yes or N for no

Y N Penicillin
Y N Antibiotics
Y N Aspirin
Y N Tylenol

Y N Codeine
Y N Narcotics
Y N Local Anesthetic
Y N Latex

Y N Ibuprofen
Y N Nitrous oxide
.0 **Y N** Bleach

Y N Iodine/Seafood
Y N Nitrile
Y N Food:_____
Y N Ethanol

Y N Gutta-percha
Y N Valium/Tranquil
Y N Sulfa/Sulfides
Other:_____

Medications

Please list all medications you are currently taking and what condition it is for.
Med.: _____ Cond.:_____ Med.: _____ Cond.:_____
Med.: _____ Cond.:_____ Med.: _____ Cond.:_____
Med.: _____ Cond.:_____ Med.: _____ Cond.:_____
Med.: _____ Cond.:_____ Med.: _____ Cond.:_____

Family Physician Information
Name_____
Phone_____ Date of last visit_____