Katrina A. Thatch, DDS- A Division of Central Virginia Dental Care, PLC
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General Health Information

Are you under a physician's care now?
Have you ever been hospitalized or had a major operation? YES NO
If yes, please explain:
Have you ever had a serious head or neck injury? YES NO
If yes, please explain:
Are you taking any medications, pills, or drugs? YES NO
If yes, please explain:

Are you currently taking any blood thinners? YES NO
If yes, please explain:
Do you take, or have you taken, Phen-Fen or Redux? YES NO
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? YES NO
Are you on a special diet? YES NO
If yes, please explain:
Do you use tobacco? YES NO
Do you use controlled substances? YES NO
If yes, please explain

Women are you:

Pregnant/Trying to get pregnant? YES NO
Taking oral contraceptives? YES NO
Breastfeeding? YES NO

Are you allergic to any of the following?

Aspirin YES NO
Penicillin YES NO
Codeine YES NO
Acrylic YES NO
Metal YES NO
Latex YES NO
Sulfa Drugs YES NO
Local Anesthetics YES NO
Other? _____

BACK

Do you have, or have you had, any of the following?

AIDS/HIV Positive	YES	NO
Alzheimer's Disease	YES	NO
Anemia	YES	NO
Artificial Heart Valve	YES	NO
Artificial Joint	YES	NO
Asthma	YES	NO
Blood Disease	YES	NO
Cancer	YES	NO
Chemotherapy	YES	NO
Cold Sores/Fever Blisters	YES	NO
Congenital Heart Disorder	YES	NO
Diabetes	YES	NO
Drug Addiction	YES	NO
Epilepsy or Seizures	YES	NO
Excessive Bleeding	YES	NO
Frequent Headaches	YES	NO
Heart Attack/Failure	YES	NO
Heart Murmur	YES	NO
Heart Pacemaker	YES	NO
Heart Trouble/Disease	YES	NO
Hemophilia	YES	NO
Hepatitis A	YES	NO
Hepatitis B or C	YES	NO
Herpes	YES	NO
High Blood Pressure	YES	NO
High Cholesterol	YES	NO
Hypoglycemia	YES	NO
Leukemia	YES	NO
Low Blood Pressure	YES	NO
Lung Disease	YES	NO
Mitral Valve Prolapse	YES	NO
Osteoporosis	YES	NO
Pain in Jaw Joints	YES	NO
Parathyroid Disease	YES	NO
Psychiatric Care	YES	NO
Radiation Treatments	YES	NO
Rheumatic Fever	YES	NO
Rheumatism	YES	NO
Stroke	YES	NO
Thyroid Disease	YES	NO
Tonsillitis	YES	NO
Tuberculosis	YES	NO
Tumors or Growths	YES	NO
Ulcers	YES	NO
Venereal Disease	YES	NO
Have you ever had any serious illness not listed above?	YES	NO

If yes, please explain:

Signature: _____