

PRACTICE OF
CHARLES R. FIELDS D.M.D., P.C.

HEALTH QUESTIONNAIRE - CONFIDENTIAL

Date _____

vers 02/11

Name: _____ Date of Birth: (month / day/ year) _____

Personal Physician's Name _____ Physician's phone #: (_____)

List of Current Medications (including any herbals / homeopathic remedies:

Known Drug Allergies and Hypersensitivities: (Circle all that apply)

Penicillins (amoxicillin / ampicillin etc) Tetracyclines Erythromycin other _____

Codeine / Demerol Aspirin (and related compounds/ ibuprofen /naproxen) Local Anesthetics (lidocaine, novocaine)

Latex Products Other Drugs _____

Medical Conditions / Diagnoses: (Circle all that apply, current **and** past)

Heart Disease Heart Attack Congestive Heart Failure Angina Anemia
Heart Murmur Rheumatic or Scarlet Fever Stroke Prosthetic Heart Valve Pacemaker
Liver Problems Abnormal Bleeding Hemophilia Asthma High Blood Pressure
Emphysema Tuberculosis Sinus Problems HIV/AIDS Diabetes (type 1 or 2? ____)
Hepatitis (type? ____) Kidney Problems Thyroid Disorders Stomach Ulcers
Epilepsy / Seizures Cancer Treatment Recent Cortisone Treatment MRSA
Osteoporosis/Osteopenia (I have taken bisphosphonate drugs recently Y or N _____) Diet Control Drugs
Alcohol or Substance Abuse Prosthetic Joint (date placed ____) Current Smoker (packs per day ____)
Other Diagnosed Conditions _____

Women : Currently Pregnant? Y / N ____ weeks

Pursuant to Virginia Code s32.1-45.1, we are required to give you the following notice: "If one of our employees should be directly exposed to your blood or body fluids in a way that may transmit disease, your blood will be tested for possible infectious microorganisms. You will be informed of the result."

I hereby attest: to comprehending English, to the validity of the above information, that it is my responsibility to inform this office of any changes. I have been made aware of the Virginia law pertaining to exposure incidents.

Signature _____
(Patient, parent or guardian)

Dr. Fields' initials _____