Clemmons Village Smiles

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PATIENT HEALTH INFORMATION

Your oral health is an important part of your overall health. General health problems & medications you may be taking can have a significant interrelationship with the dentistry we perform. Please answer the following questions as accurately as possible!

Are you under a physician's care for anything other than routine physicals/check-ups? ❑ Yes ❑ No
If yes, what for? _____
Have you been hospitalized or had a major operation in the last 3 years? ❑ Yes ❑ No
If yes, for what reason? _____
Have you ever been told to take **Antibiotic Premedication** prior to dental work? ❑ Yes ❑ No
If yes, for what reason? _____
Have you ever taken **Bisphosphonates** (bone density medication for osteoporosis)? ❑ Yes ❑ No
Are you taking any prescription medications or supplements? ❑ Yes ❑ No
If yes, list names and dosages below:

Women only:

Pregnant or trying to get pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Do you have, or have you previously had, any of the following? ❑ No ❑ Yes (check items below)

- ❑ Allergy – Anesthetic
- ❑ Allergy – Acrylic
- ❑ Allergy – Codeine
- ❑ Allergy – Penicillin
- ❑ Allergy – Sulfa Drugs
- ❑ Allergy – Latex
- ❑ Allergy – Metal
- ❑ Allergy (Other): _____
- ❑ Anaphylaxis
- ❑ Alcohol Abuse
- ❑ Anemia
- ❑ Arthritis/Gout
- ❑ Artificial Joint(s)
- ❑ Asthma
- ❑ Bisphosphonate Use/Osteoporosis
- ❑ Blood Thinners
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Chest Pain/Angina
- ❑ Cigarette Smoking/Vaping
- ❑ Dry Mouth
- ❑ Diabetes
- ❑ Drug Addiction
- ❑ Epilepsy/Seizures
- ❑ Fainting/Dizziness
- ❑ Frequent Headaches/Migraines
- ❑ Glaucoma
- ❑ High Cholesterol
- ❑ Heart Attack/Failure
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Heart Valve Replacement
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ HIV
- ❑ Hypoglycemia (Low Blood Sugar)
- ❑ High Blood Pressure
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Memory Issues (Alzheimer's)
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorders (Anxiety)
- ❑ Pacemakers
- ❑ Pain in Jaw Joints (TMJ)
- ❑ Parkinson's
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Shingles
- ❑ Sinus Problems
- ❑ Sleep Disorders/Sleep Apnea
- ❑ Smokeless tobacco use
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other Illness not listed?
  Describe: _____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient/Guardian: _____ **Date:** _____