Clemmons Village Smiles
2265 Lewisville Clemmons Road, Suite A
Clemmons, NC 27012
336.766.1366

Patient Health Information

Your oral health is a crucial part of your overall well-being. General health issues and medications you take can significantly impact the dental care we provide. 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:

Have you ever had or do you currently have 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 Abuse (Past or Present)
☐ 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:
____
____

Women only:

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

To the best of my knowledge, I have answered all questions on this form accurately. I understand that providing incorrect information can be harmful to my (or the patient's) health. I will inform the dental office of any changes in my medical status.

Signature of Patient/Guardian: ______________________________ **Date**: ______________

Doctor Review: ______________________________ **Date**: ______________