Clemmons Village Smiles
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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 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:
_____
_____

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**: _____