Last Name ____________________ First Name ____________________ Date of Birth DAY MO YEAR

Physician Name ________________________________ Physician Phone No. ____ – ____ – ____

Most recent physician visit DAY MO YEAR Purpose of visit ____________________

How would you describe your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check if your answer is YES to any of the following questions:

1. ☐ hospitalization for illness or injury
2. an allergic reaction to:
   - ☐ aspirin, ibuprofen, acetaminophen, codeine
   - ☐ penicillin
   - ☐ erythromycin
   - ☐ tetracycline
   - ☐ sulpha
   - ☐ local anesthetic
   - ☐ fluoride
   - ☐ metals (nickel, gold, silver, ______________)
   - ☐ latex
   - ☐ other ____________________
3. ☐ heart problems or cardiac stent within the last 6 months
4. ☐ history of infective endocarditis
5. ☐ artificial heart valve or repaired heart defect (PFO)
6. ☐ pacemaker or implantable defibrillator
7. ☐ artificial joints
8. ☐ rheumatic or scarlet fever
9. ☐ high or low blood pressure
10. ☐ stroke
11. ☐ anemia or other blood disorder
12. ☐ prolonged bleeding
13. ☐ emphysema or sarcoidosis
14. ☐ tuberculosis
15. ☐ asthma
16. ☐ breathing or sleep problems (e.g. snoring, apnea)
17. ☐ kidney disease
18. ☐ dialysis
19. ☐ liver disease
20. ☐ jaundice
21. ☐ thyroid, parathyroid disease or calcium deficiency
22. ☐ hormone deficiency
23. ☐ high cholesterol or taking statin drugs
24. ☐ diabetes
25. ☐ stomach or duodenal ulcer
26. ☐ digestive disorder (e.g. gastric reflux)
27. ☐ osteoporosis/osteopenia
28. ☐ arthritis
29. ☐ glaucoma
30. ☐ contact lenses
31. ☐ head or neck injuries
32. ☐ epilepsy, convulsions (seizures)
33. ☐ neurologic problems (attention deficit disorder)
34. ☐ viral infections and cold sores
35. ☐ any lumps or swelling in the mouth
36. ☐ hives, skin rash, hay fever
37. ☐ venereal disease
38. ☐ hepatitis (type ___)
39. ☐ HIV/AIDS
40. ☐ cancer
41. ☐ radiation therapy
42. ☐ chemotherapy
43. ☐ psychiatric/mental disorder
44. ☐ alcohol/drug dependency
45. ☐ organ transplant

Are you:

46. ☐ presently being treated for any other illness
47. ☐ aware of a change in your overall health
48. ☐ taking dietary supplements
49. ☐ often exhausted or fatigued
50. ☐ subject to frequent headaches
51. ☐ a smoker or smoked previously
52. ☐ a recreational cannabis user
53. ☐ FEMALE - taking birth control pills
54. ☐ FEMALE - pregnant
55. ☐ MALE - prostate disorders

Describe any current medical treatment, impending surgery or other treatment that may possibly affect your dental treatment.

____

____

List all medications, supplements and/or vitamins you are currently taking.

Drug ____________________ Dosage __________ Purpose ____________________

Drug ____________________ Dosage __________ Purpose ____________________

Drug ____________________ Dosage __________ Purpose ____________________

Drug ____________________ Dosage __________ Purpose ____________________

I, the undersigned, understand that the information contained in my medical history is important to my dental treatment. I certify that all the information is correct and that I have not knowingly omitted any information. I consent to the release of medical information from my physician or other health provider as required by Village Dental to perform diagnostic procedures and provide necessary treatment.

Signature of patient, parent or guardian ______________________________ Date DAY MO YEAR